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ABSTRACT

This report helps state and local decision makers understand the range of services ordinarily needed and provided in alcohol and drug treatment programs serving women and families receiving welfare and how those services support the goals of welfare reform. The model programs profiled here tend to the needs of women on welfare and their families through a comprehensive array of health, social, treatment, education, and employment training services. The report describes: "Welfare as We Know It Now"; "Women, Addiction, and Treatment"; "Critical Components of Alcohol and Drug Treatment for Women; "Model Programs: Results"; "Barriers to Treatment for Women with Children"; "Recommendations"; and "Work Models That Work." The report profiles seven individual model programs in California, Florida, Illinois, Maine, Maryland, New York, and Ohio. Nine appendixes present data on these state programs: state decisions on the ban of TANF and Food Stamps for individuals convicted of drug felonies; state decisions on screening and testing welfare recipients for alcohol and drug problems; programs profiled by state; matrix of information domains explored; survey instrument; program funding sources; welfare client profiles by program; key aspects of state welfare policies toward recipients with alcohol and drug problems; and sample general treatment admission criteria. (SM)

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Steps to Success

HELPING WOMEN with Alcohol and Drug Problems Move from Welfare to Work

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MISSION STATEMENT

Established in 1972, the Center's mission is to:

- Fight discrimination against people who are in recovery or suffering from alcoholism or drug dependence.
- Fight discrimination against people with HIV or AIDS.
- Expand treatment and prevention services for people with HIV/AIDS and people with alcohol and drug problems.

STEPS TO SUCCESS

HELPING WOMEN
with Alcohol and Drug Problems
Move from Welfare to Work

May 1999

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The treatment programs profiled here are models in tending to the needs of women on welfare and their families through a comprehensive array of health, social, treatment, education, and employment training services.

Introduction

When we proposed this project, the 1996 federal welfare law[1] and the Temporary Assistance to Needy Families (TANF) program it created were one year old. We believed then – and we still believe – that state and local policy makers and advocates are hungry for information about how to implement the new law so that it promotes treatment, sustained recovery, and self-sufficiency for welfare recipients with alcohol and drug problems. Our work over the last year with them has only strengthened that belief.

Most studies have estimated that between 15 and 20 percent of welfare recipients have alcohol and drug problems. Many will need treatment to succeed in finding and keeping jobs, which could translate into as many as 400,000 to 800,000 individuals seeking treatment. Yet current treatment capacity in the public system can accommodate only about 50 percent of the need overall, even less for women.[2]

Decisions about how to handle the alcohol and drug problems of welfare recipients could also have serious financial implications for state and local budgets.

Given work requirements and impending time limits, in addition to historic declines in the number of Americans receiving welfare in the last couple of years, state and local officials have quickly begun to face decisions about how to address the needs of long-term welfare recipients who have significant barriers to employment, including alcohol and drug problems. If these decisions impede or reduce access to alcohol and drug treatment or make treatment and work requirements incompatible,[3] they could cause undue harm to families receiving welfare. Other studies have documented these concerns.[4]

Decisions about how to handle the alcohol and drug problems of welfare recipients could also have serious financial implications for state and local budgets. A recent study that examined alcohol and drug problems as a predictor of receiving welfare benefits in California concluded that local general assistance programs would be the final safety net for recipients removed from federal programs and that these local programs could be confronted with clients with more complex disabilities related to addiction, as well as with greater family needs for cash assistance.[5]

We designed this project with those state and local officials – and this dilemma – in mind. The treatment programs profiled here are models in tending to the needs of women on welfare and their families through a comprehensive array of health, social, treatment, education, and employment training services. All of them are in the business of helping women move into recovery, off welfare, and into jobs.

Our main goal in undertaking this work is to help state and local decision makers understand the range of services ordinarily needed and provided in alcohol and drug treatment programs serving women and families receiving welfare and how those services support the goals of welfare reform. We hope that decision makers will be able to use this knowledge to find treatment resources already available and working for women with children in their own communities, whether or not programs in their communities are profiled here.

The 1996 Federal Welfare Law and Its Effects on Individuals With Alcohol and Drug Problems

The 1996 welfare law transformed federal cash welfare programs into a capped block grant called the Temporary Assistance for Needy Families (TANF) program. The TANF program provides states with broad flexibility for designing their welfare programs, but also imposes specific work requirements on welfare recipients and sets a five-year lifetime limit on federal assistance.

Without welfare and food stamps, some women and children would not be able to afford basic living necessities, including food, shelter, and health care.

The new law contains three specific provisions that will have particular impact on recipients with histories of alcohol and drug problems and the treatment programs serving them:

- Section 115 makes individuals with drug felony convictions[6] ineligible for TANF and food stamps – unless the state enacts legislation to opt out of or modify the ban. As of February 1999, about half the states (24) had decided to follow the ban, including some with large welfare caseloads, such as California. (More specific information about state decisions on benefits for individuals with drug felony convictions appears in Appendix I.)

- Sections 408(a)(9), 821, 202, and 903 (respectively) make individuals in violation of a condition of their parole or probation ineligible for TANF, food stamps, Supplemental Security Income (SSI), and public housing, although without defining what constitutes a violation. For SSI and food stamps, the ineligibility applies "during such month" and "during any period," respectively, that the individual is out of compliance; for TANF and public housing, the period of ineligibility is not defined further in the law.

- Section 902 authorizes but does not require states to test welfare recipients for illegal drug use and sanction those who test positive. After the law was enacted, a handful of states – including New York and Maryland – announced that they intended to require urine drug tests of all welfare recipients. They later determined that other types of screening and assessment were more effective and less costly.

  Michigan recently enacted a law requiring urine drug testing of all welfare recipients.[7] Only four other states are requiring drug tests for any welfare recipients. Minnesota, New Jersey, South Carolina, and Wisconsin are randomly testing those with felony drug convictions. (More specific information about how states have decided to screen welfare recipients for alcohol and drug problems appears in Appendix II.)

Each of these provisions could have serious consequences for low-income individuals and families. Without welfare and food stamps, some women and children would not be able to afford basic living necessities, including food, shelter, and health care.

Each of these provisions also has the potential to reduce available funding for alcohol and drug treatment for women on welfare and their families. Alcohol and drug treatment programs, particularly residential programs, have historically used a family's wel-

fare and food stamps to help fund services. If these funds are no longer available, programs could be forced to reduce services or close if they cannot offset the losses.

State eligibility decisions have already affected the financial resources available to some families and programs. In fact, 15 percent of the programs profiled in this report have already had clients denied welfare and food stamps because of felony drug convictions. This percentage is only going to increase, as those individuals convicted of a drug felony since the enactment of the law who were incarcerated complete their sentences.

On the other hand, states now have the flexibility to fund treatment directly using federal and state TANF funds.[8] In states that opt to do so, this could help offset treatment provider losses related to clients' individual loss of benefits, although it would not help provide direct support to families.

State eligibility decisions have already affected the financial resources available to some families and programs. In fact, 15 percent of the programs profiled in this report have already had clients denied welfare and food stamps because of felony drug convictions.

The 1997 Welfare-to-Work Law and Its Effects on Welfare Recipients with Alcohol and Drug Problems

The 1997 welfare-to-work law,[9] administered federally by the Department of Labor and locally by Private Industry Councils (PICs), now known as Workforce Investment Boards (WIBs),[10] is aimed at funding programs that serve long-term welfare recipients. The law specifically targets those "requiring substance abuse treatment for employment."[11]

Federal guidelines to implement the program make clear that alcohol and drug treatment falls within the scope of "job retention and supportive services" authorized in the law,[12] as long as they are not medical services, which cannot be paid for through TANF.[13]

The program has two main components:

- 75 percent of the funding is distributed through formula grants to states, although six states are not participating in this part of the program – Idaho, Mississippi, Ohio, South Dakota, Utah, and Wyoming.[14]
- A little less than 25 percent of the funding is distributed to state and local entities through a competitive grant process.[15]

The most recent federal solicitation for competitive grant applications placed a "high priority" on five specific populations facing specific challenges, one of which is "individuals who require substance abuse treatment."[16] According to the solicitation, applications targeting one of these priority populations may be eligible for bonus points during review. As a result, the program could become a short-term source of additional funding for alcohol and drug treatment for welfare recipients.

Tracking the Success of Welfare Recipients Since the Enactment of the 1996 Law

In early 1998, news reports began trumpeting the success of the 1996 law as the number of Americans on welfare had fallen to its lowest level in 30 years.[17] Between early January 1997 and June 1998, more than one million individuals left welfare, a 26 percent decline.[18] In some states, caseloads dropped by more than 50 percent.

No one knows, however, what exactly is happening to these families, although some states and others are trying to track outcomes. Unfortunately, the low response rates of most state tracking studies have made it difficult to draw solid conclusions. But a recent compilation[19] reported the following:

- About half (50 to 60 percent) of recipients who leave welfare find jobs.
- Many recipients (40 to 50 percent) who are sanctioned also find work.
- Most welfare recipients find jobs that pay between $5.50 and $7 an hour, higher than the minimum wage but not enough to raise a family out of poverty.
- Most families continue to receive some form of public assistance – such as food stamps, child care subsidies, and Medicaid – after they leave TANF.
- About one-fifth (20 percent) of the families that leave welfare return within several months.

No studies have yet focused attention on what has happened to the subset of families affected by addiction, who are considered among the hardest-to-serve welfare recipients.

After examining outcomes in seven states, the U.S. General Accounting Office (GAO) also concluded that while early results appear promising, it is too early to draw definitive conclusions. GAO specifically noted that little was known about program effects on children and families, including child welfare and family stability.[20]

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Alcohol and Drug Problems Among Women

Recognition of alcohol and drug problems among women has increased in the last several decades, as has attention to the treatment needs of women. But differences in data collection, the definitions chosen, and the subpopulation studied make it difficult to draw definitive conclusions about alcohol and drug abuse and dependence among women, including how many women need treatment.

Overall, most research indicates that the prevalence of alcohol and drug problems among women is highest among young women (ages 18-34), women who are unemployed, women who have never been married, and women who first used alcohol or drugs in their early teens. Most available research also concludes that the prevalence of alcohol and drug problems among women is lower than among men.

Overall, most research indicates that the prevalence of alcohol and drug problems among women is highest among young women (ages 18-34), women who are unemployed, women who have never been married, and women who first used alcohol or drugs in their early teens.

Findings from studies that have examined the problem of alcohol and drug use and abuse by women include:

- Past Month Use – Recent analysis of data aggregated from the 1979-1995 National Household Surveys on Drug Abuse (NHSDA) concluded that 4.5 percent of American women 12 years and older had used drugs in the past month and 8.5 percent had engaged in "binge" drinking (defined as drinking five or more alcoholic drinks on the same occasion on at least one day in the past 30 days).[21] Past month drug use or binge drinking does not necessarily indicate a problem that rises to the level of needing treatment.
- Use During Pregnancy – A study of the prevalence of alcohol and drug use during pregnancy found that, among women who gave birth between October 1992 and August 1993, 18.8 percent had used alcohol and 5.5 percent had used some drug during their pregnancy.[22] Alcohol and drug use during pregnancy, while potentially harmful to the developing fetus, do not necessarily indicate a need for treatment.
- Use Among Mothers – Analysis of data from the 1995 NHSDA and 1991 data from the Drug Abuse Warning Network (DAWN) estimated that 5.7 percent of women ages 15-44 with children at home had used drugs in the past month (compared to 11.2 percent of women without children at home) and 4 percent of mothers had engaged in binge drinking in the last month.[23] (Again, binge drinking or drug use in the past month does not necessarily indicate a need for treatment.)

Alcohol and Drug Problems Among Welfare Recipients

Several studies[24] of national data collected and analyzed before the creation of the TANF program have estimated that between 10 and 20 percent of adult welfare recipients have alcohol or drug problems. States that have collected their own data have higher estimates, including Oregon and Kansas, which reported in 1997 that at least 50 percent of their welfare caseloads had alcohol or drug problems.[25]

Two studies have examined the issue of how many welfare recipients have alcohol and drug problems that will interfere with working or require treatment. The first, based on 1991-1992 data from the NHSDA, estimated that 5.2 percent of adult welfare[26] recipients were significantly impaired and 11.2 percent were somewhat impaired by alcohol

and drugs.[27] The second, based on 1992 data from the National Longitudinal Alcohol Epidemiologic Study, estimated that 7.3 percent of women on welfare abused or were dependent on alcohol and 3.3 percent abused or were dependent on drugs.[28]

The Alcohol and Drug Treatment System for Women and Women on Welfare

Clearly, a significant number of welfare recipients will need alcohol and drug treatment to enter recovery, leave welfare, and find and keep jobs. The 15 to 20 percent estimate could translate into 400,000 to 800,000 individuals, mostly women with children, seeking treatment in the publicly funded system. This could pose serious problems for treatment programs serving women, which are not able to meet even the current need and demand for services.

Despite the creation of gender-specific treatment programs 15 to 20 years ago, women continue to be under-represented in treatment, making up less than 30 percent of all treatment admissions to publicly funded programs between 1992 and 1996.

Despite the creation of gender-specific treatment programs 15 to 20 years ago, women continue to be under-represented in treatment, making up less than 30 percent of all treatment admissions to publicly funded programs between 1992 and 1996.[29,30] One-third of the states (17) reported gaps in treatment services for women in Fiscal Year 1994, such as the need for halfway houses and transitional housing, child care, transportation, and more services for women in rural areas, including prenatal and medical care for pregnant and post-partum women.[31]

Women, particularly pregnant women and women with children, have been and continue to be underserved in the alcohol and drug treatment system, which was originally based on models of care for men, primarily alcoholic men. These models do not address the special issues women bring into treatment, such as the need for child care. The increase in gender-specific treatment has not entirely abated these problems. A 1993 study documented the comparative difficulty pregnant women on Medicaid and women needing child care have finding treatment programs that will accept them.[32]

Women needing alcohol and drug treatment are still less likely to receive it than men. A study based on 1991-1993 NHSDA data found that 41 percent of women compared to 47 percent of men needing treatment received it. Among those receiving welfare assistance, the gap was larger still – 48 percent of women compared to 61 percent of men needing treatment received it.[33] A study based on 1994-95 NHSDA found that 36.6 percent of women with drug problems had been in treatment in the past year, compared to 47.8 percent of men.[34]

Funding for gender-specific treatment increased in the 1980s but has markedly decreased in the early 1990s. Federal categorical programs targeted at pregnant and parenting women have been phased out of the budget of the federal Center for Substance Abuse Treatment (CSAT). Funding will end this fiscal year for the majority of grantees.

Medicaid, which most families on welfare rely on for health services, is not a significant source of funding for alcohol and drug treatment programs in many communities. Treatment services are optional under the program; consequently, some states cover little or no services. Reimbursement is also expressly disallowed for all Medicaid-covered services provided to recipients between 22 and 64 years of age in treatment facilities classified as "Institutions for Mental Diseases" (IMDs). IMDs are facilities with more than 16 treatment beds that provide care for individuals with "mental diseases," with substance abuse included in the definition of "mental diseases." This means that resi-

dential treatment programs serving women must decide either to limit their size to 16 or fewer treatment beds or forego Medicaid as a source of funding.

Changes in welfare law have added a new funding complication. Some alcohol and drug treatment programs will no longer be able to tap into the welfare and food stamps of clients who have felony drug convictions, as well as the benefits of those who have reached their TANF time limits or have been sanctioned. Without replacement funding, these programs could be forced to reduce or discontinue services, widening the treatment gap for families on welfare – at precisely the time they need it most.

Alcohol and Drug Treatment Outcomes for Women With Children

Numerous studies have shown that alcohol and drug treatment programs provide effective and cost-effective services. Programs serving women with children, including women on welfare, have also demonstrated such key positive outcomes as decreased alcohol and drug use, increased employment and earnings, decreased use of public assistance, increased family stability, and decreased crime.

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A report on outcomes among women with children receiving welfare and treatment in California in 1991 and 1992 concluded that treatment was useful and cost-beneficial for families and individuals receiving public assistance.[35] Treatment reduced alcohol and drug use, crime, homelessness, and hospitalizations for women with children on welfare, with benefits exceeding costs by two and one-half times. This is an underestimate for several reasons, including that post-treatment employment and earnings data were deflated by a recession in the state at the time of the study and that the study did not count costs averted in the child welfare system (a system in which welfare families affected by alcohol and drug problems are likely to be involved).

The National Treatment Improvement Evaluation Study (NTIES), which examined outcomes for 1,374 women served in federally funded alcohol and drug treatment programs, found that the women treated:[36]

- Reduced their drug use by more than 40 percent for as long as a year after leaving treatment, even when clients who only completed an intake interview and returned for at least one single visit are included.
- Increased their employment and decreased their use of welfare programs. Those who reported being employed in the year following treatment increased by 25 percent, with nearly half of respondents reporting employment. Income rose modestly, up 6 percent, while the number receiving public assistance decreased by 8 percent.
- Dramatically decreased their involvement in illegal activities – arrests declined by 67 percent, drug selling decreased by 82 percent, and shoplifting decreased by 88 percent.

Recent evaluations[37] of women treated through two federal programs for pregnant and parenting women revealed positive results in decreased drug use, decreased involvement with the criminal justice system, and increased employment. Women who completed treatment through the Pregnant and Postpartum Women with Infants (PPWI) program[38] increased their employment more than eightfold – from 5 percent employed full- or part-time at admission to 41 percent employed full- or part-time at follow-up. Those who completed treatment through the Residential Women with Children (RWC) program[39] increased their employment sevenfold – from 4 percent at admission to 28 percent at follow-up.

The Services Research Outcomes Study, which interviewed 1,799 individuals (515 of whom were women) five years after their discharge from treatment in 1990, found that the post-treatment decrease in drug use (marijuana, cocaine, crack, and heroin) was greater for women than for men. Women also had significant reductions in crime, including drug selling (down 37 percent), prostitution (down 23 percent), theft and larceny (down 41 percent), and driving under the influence (down 34 percent).[40]

Critical Components of Alcohol & Drug Treatment for Women

The federal Center for Substance Abuse Treatment (CSAT) recommends that the following services, among others, be provided either on-site or through referral as part of the treatment process for women:

Medical Interventions

- Testing and treatment for infectious diseases, including hepatitis, tuberculosis, HIV, and sexually transmitted diseases (STDs).
- Screening and treatment of general health problems, including anemia and poor nutrition, hypertension, diabetes, cancer, liver disorders, eating disorders, dental and vision problems, and poor hygiene.
- Obstetrical and gynecological services, including family planning, breast cancer screening, periodic gynecological screening (e.g., pap smears), and general gynecological services.
- Infant and child health services, including primary and acute health care for infants and children, immunizations, nutrition services (including assessments for Women, Infants, and Children (WIC) program eligibility), and developmental assessments by qualified personnel.

Addiction Counseling and Psychological Counseling

- Counseling about the use and abuse of alcohol and drugs directly, as well as other related issues that may include low self-esteem, race and ethnicity issues, gender-specific issues, disability-related issues, family relationships, unhealthy interpersonal relationships, violence (including incest, rape, and other abuse), eating disorders, sexuality, grief related to the loss of children, family, or partners, sexual orientation, and responsibility for one's feelings, including shame, guilt, and anger.
- Parenting counseling, including information on child development, child safety, injury prevention, and child abuse prevention.
- Relapse prevention, which should be a discrete component or phase of women's recovery plans.

Health Education and Prevention Activities

- Covering HIV/AIDS, the physiology and transmission of STDs, reproductive health, preconception care, prenatal care, childbirth, female sexuality, childhood safety and injury prevention, physical and sexual abuse prevention, nutrition, smoking cessation, and general health.

Life Skills

- Practical life skills, vocational evaluation, financial management, negotiating access to services, stress management and coping skills, and personal image building.
- Parenting, including infant/child nutrition, child development, and child/parent relationships.
- Educational training and remedial services, including access to local education and GED programs and other educational services identified at intake.
- English language competency and literacy assessment programs should be facilitated.
- Job counseling, training, and referral.

Other Social Services

- Transportation for clients to gain access to alcohol and drug treatment services and related community services.
- Child care.
- Legal services.
- Housing.

Source: Center for Substance Abuse Treatment, Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs, 1994.

Methodology

The goals of this project were to (1) identify model treatment programs that help women make the transition into recovery, off welfare, and into jobs and (2) widely disseminate those program models to policy makers, service providers, and advocates to help them learn from and replicate those successes. The project was conducted in three phases over the course of one year.

During Phase I, we identified model treatment programs for women with children that are effectively moving women on welfare into recovery and jobs. We sought out programs in three ways. First, we contacted programs identified by directors of state alcohol and drug agencies and directors of state welfare agencies in a 1997 survey we conducted on a variety of welfare- and addiction-related topics. Second, we consulted with members of the National Coalition of State Alcohol and Drug Treatment and Prevention Associations, which includes 33 treatment and prevention provider organizations in 25 states. Third, we identified other programs through an informal "snowball" process with a network of contacts with publicly funded treatment programs developed by the Center over more than 25 years.

Phase II of the project consisted of choosing states and programs for site visits. We used a variety of criteria for choosing states and programs to visit, including geographic diversity, population and population density, and comparative welfare caseloads. For example, we visited states in five key regions of the country – the West (California), Midwest (Illinois and Ohio), Northeast (New York and Maine), South (Florida), and mid-Atlantic (Maryland). We visited programs in urban (New York City, Chicago, Baltimore, and Los Angeles), suburban (Rockville, Maryland, and Rockford, Illinois), and more rural areas (Athens, Ohio, and Peoria, Illinois). (A list of the 20 programs visited in seven states appears in Appendix III).[41]

During site visits, we met with treatment providers and clients to discuss the key components of program success, including program elements, practices, principles, and goals, client and treatment provider responsibilities, and other quantitative and qualitative information identified as valuable.

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We developed a matrix to guide the information goals of the project. The matrix helped us design a questionnaire we distributed to participating treatment programs to collect systematic information about their welfare caseloads, treatment services offered, work and work training offered, supportive services offered, funding sources, experiences so far with welfare reform, and expectations for the future. (The matrix and full questionnaire appear in Appendixes IV and V.) We also requested information about program evaluation data.

During Phase III, we visited each of the programs.[42] Program visits lasted for a half day or more, depending on scheduling and availability. Site visits consisted of meeting with program staff (both administrative and clinical) and clients, with particular attention to job training and education components of treatment. Follow-up was conducted to ensure as complete a response as possible to the questionnaire, as well as to review the accuracy of the profiles contained in this report. Providers received pre-publication review copies of the descriptions of their programs to ensure accuracy.

Profiles of the Programs Visited

The 20 women's treatment programs profiled in this report serve low-income women with children who, for the most part, do not have private health insurance and receive welfare assistance.

The 20 women's treatment programs profiled in this report serve low-income women with children who, for the most part, do not have private health insurance and receive welfare assistance. They accept all clients, regardless of ability to pay, and rely on myriad federal, state, and local funding agencies to support their activities.

Funding Sources

These programs received financial support from multiple federal, state, and local funding sources. Most relied on at least three funding sources to support their women's services, ranging from one program relying entirely on a single source to another program that received support from 10 separate funding sources. (Detailed information about each program's funding appears in Appendix VI.)

On average, the programs received about one-third (32 percent) of their funding from two federal funding sources – the Substance Abuse Block Grant and categorical programs in the Substance Abuse and Mental Health Services Administration (SAMHSA). On average, a little less than one-third (28 percent) came from state and local appropriations.

Public assistance programs provided, on average, about another quarter (23 percent) of the funding, with Medicaid furnishing most of that (16 percent), and TANF (6 percent) and food stamps (2 percent) making up the rest.

Other programs contributed smaller amounts to the average overall funding picture, including federal, state, and local housing agencies (5 percent), private health insurance (2 percent), criminal and juvenile justice agencies (3 percent), the Ryan White CARE Act[43] (1 percent), and client payments (2 percent).

Variations were wide, however, in funding patterns among programs. For example, five programs reported that TANF made up 10 percent or more of their funding, while ten programs reported receiving no TANF funding at all. Programs reported similar variances for Medicaid, with seven reporting that Medicaid supplied 10 percent or more of their funding and nine reporting that they received no Medicaid funding at all.

Referral Sources

The programs receive clients through a number of referral sources, including organizations and providers in both public and private sectors. Almost all received referrals from the welfare (90 percent), child welfare (95 percent), criminal/juvenile justice (90 percent), mental health (84 percent), and public health (84 percent) systems. Most also took referrals from local private health care providers (79 percent) and managed care organizations (60 percent). But only about one-third (31 percent) received referrals from the education system.

Work and Work Training Activities Provided

The programs reported providing numerous work and work training activities for their clients. While more than half (60 percent) required work and vocational training as part of treatment, less than half (40 percent) required these activities to graduate from treatment. Three-quarters of the programs (75 percent) provided work and vocational training concurrently with treatment, not consecutively.

Three-quarters of the programs (75 percent) provided work and vocational training concurrently with treatment, not consecutively.

Nearly two-thirds (65 percent) of the programs offered work and vocational training on-site. Almost all provided linkages to other community-based literacy programs (90 percent) and high school equivalency (GED) programs (95 percent).

Support Activities Offered

The programs reported offering a variety of support components to welfare treatment clients both during and after treatment. Almost all (95 percent) provided affordable child care and transportation services during treatment.

Most of the programs (90 percent) provided clean and sober housing for clients in treatment. Fewer, although still nearly two-thirds (65 percent), had clean and sober housing available for clients who had completed treatment.

All 20 programs (100 percent) reported that they provided parenting training. All also reported that they provided exit planning, to help clients prepare for maintaining their recovery and resuming their lives outside of the treatment community.

Evaluation Criteria Analyzed

Most of the programs (89.5 percent) reported that they collect both process and outcome data to help measure their success. Two programs (10.5 percent) reported that they only collect outcome data.

A majority of the programs reported collecting data about clients' participation in work and vocational training (63 percent), employment (68 percent), and welfare programs (58 percent). Fewer – a little less than one-third (32 percent) of the programs – reported collecting data about clients' earnings.

Effects of Changing Welfare Law on the Programs

During site visits, most providers expressed concerns about how changes in federal and state welfare laws had affected their clients (Appendix VIII outlines key facets of policies in the states where these programs are located toward welfare recipients with alcohol and drug problems). In a written survey:

- Three-quarters (75 percent) reported that referrals from state or local welfare agencies have not increased. This was true even in states and localities with well-publicized efforts aimed at identifying welfare recipients with alcohol and drug problems and referring them to treatment.

Nearly three-quarters [of programs] (74 percent) thought their revenue would decrease or stay the same. Only about one-quarter (26) thought they would have more revenue with which to treat their larger client caseload.

- More than half (55 percent) reported problems in having alcohol and drug treatment services authorized or reimbursed for women on welfare.
- A little less than one-sixth (15 percent) reported having clients denied welfare and food stamps as a result of a drug felony conviction. This percentage is likely to increase, given that women convicted of these felonies since the enactment of the 1996 welfare law who are incarcerated are likely still to be serving their sentences.
- A little less than one-sixth (15 percent) reported having clients denied welfare or food stamps because they were in violation of a condition of parole or probation.

During site visits, most providers also expressed concern about how changes in the law and its implementation were going to affect their programs in the future. The survey yielded the following:

- More than half of the providers (60 percent) predicted that their client caseload would increase, and 25 percent predicted it would stay about the same. Only 15 percent thought it would decrease. While, by itself, increasing the number of women going to treatment would be a positive effect of welfare reform, this increase will take place in a context characterized in many places by shortages of treatment beds for these women and their children.
- Nearly three-quarters (74 percent) thought their revenue would decrease or stay the same. Only about one-quarter (26) thought they would have more revenue with which to treat their larger client caseload.
- Most providers (65 percent) predicted that the number of publicly funded treatment beds or slots in their program would stay the same, while 20 percent predicted they would decrease and 15 percent thought they would increase.
- The majority of providers (55 percent) thought that their staff size would also stay the same, and 25 percent thought it would decrease. The other 20 percent thought it would increase.
- The majority of providers (60 percent) predicted that their program size would stay the same, and another 15 percent predicted it would decrease. One-quarter (25 percent) thought it would increase.

Profiles of Clients on Welfare Served by the Programs in this Study

The welfare clients served by the programs profiled arrive in treatment with a variety of problems and challenges. Many have long histories of unemployment and involvement with the criminal justice system; some cannot read, and many have been victims of domestic violence. (More specific information about each program's clients appears in Appendix VII.)

According to providers, of the clients being served in their programs:

- About one-sixth (15 percent) have had a felony drug conviction.
- Nearly one-quarter (23 percent) were in treatment as a condition of parole or probation.
- A little less than half (46 percent) were involved with the child welfare system.
- A little less than half (48 percent) have been victims of domestic violence.
- About three-quarters (74 percent) had a history of relapse.
- The majority (81 percent) had a history of being chronically unemployed.
- More than half (53 percent) did not have a high school diploma or GED.
- More than one-third (38 percent) had a mental illness in addition to their alcohol or drug problem.
- A few (4 percent) were HIV positive.

Many [welfare treatment clients] have long histories of unemployment and involvement with the criminal justice system; some cannot read, and many have been victims of domestic violence.

Limitations of the Data Presented

Data reported here were collected through a survey of the 20 alcohol and drug treatment programs providing services to pregnant and parenting women we visited in 1998. The programs were not randomly selected and, therefore, may not be representative of treatment programs as a whole or of treatment programs serving pregnant and parenting women.

Many of the programs are current or former grantees of CSAT, which requires them to provide a rich array of services, including prenatal, postpartum, and pediatric health care, parenting training, HIV counseling, and counseling on obtaining employment.[11] This array of services may not be available to women not served in CSAT-funded programs.

These data are time limited. They describe services provided, funding received, and clients served during 1998. They may not reflect historical patterns in the treatment of alcohol and drug problems among pregnant and parenting women, and they may not be predictors of future trends in the system.

Barriers to Treatment for Women With Children

Despite the efficacy of services, women with children face many barriers to entering treatment. Among the most powerful are:

- Financial concerns, both loss of income and problems paying for treatment, were cited in a 1996 report that assessed women's treatment needs in Iowa.[1]

- Stigma. Many experts have written about the intense feelings of guilt, shame, and low self-esteem experienced by women with alcohol and drug problems. These emotions can lead to an immobilizing sense of depression and isolation and ultimately prevent women from asking for help, including treatment. Stigma can be even greater for alcoholic and drug dependent mothers who are viewed as "demons" by society.

- Lack of child care. Few treatment programs provide child care, and this has been identified as a primary barrier to seeking treatment for alcohol and drug dependent women.[3,4] Data analyzed from 1995 showed that only 12.9 percent of publicly funded treatment facilities offered child care.[5] Yet the availability of programming where women can take their children to treatment with them has been associated with improved retention in treatment and treatment success.[6]

- Fear of losing custody of their children. Mothers with alcohol and drug problems fear losing their children if they come forward for treatment. Some states and localities have taken punitive action against pregnant drug and alcohol dependent women, including automatic reporting to child protective services and removal from the home. In a 1995 survey, more than half (58 percent) of state alcohol and drug directors and child protective services directors reported that a positive drug test was grounds for reporting a pregnant woman to the state child welfare, health, or criminal justice agency, compared to 12 percent in 1992.[7]

- Fear of prosecution. Mothers with alcohol and drug problems fear prosecution, and prosecutions have increased in the 1990s. In a 1995 survey, nearly three-quarters (71 percent) of state alcohol and drug directors and child protective services directors reported that drug-using women had been prosecuted in their state, compared to fewer than half (45 percent) who reported so in 1992.[8] In 1996, the South Carolina Supreme Court ruled that women can be held criminally liable for actions taken during pregnancy, specifically drug use, that might affect their viable fetus.[9]

- Experience with violence. Women with alcohol and drug problems report high rates of violence, including rape, incest, and domestic violence. Suppression of past violent experiences is identified throughout the literature as a major relapse trigger and is a critical issue that must be addressed as women move into recovery.

[1] University of Iowa College of Education, "Alcohol and Drug Abuse Among Iowa Women: Iowa State Needs Assessment Project," April 1996.

[3] Vicki Breitbart, et. al., "The Accessibility of Drug Treatment for Pregnant Women: A Survey of Programs in Five Cities," *American Journal of Public Health*, Volume 84 (1994), pp. 1658-1661.

[4] "Why Women Need Help: Hazelden Survey Reveals Denial and Access Issues," *Substance Abuse Report*, June 1, 1996.

[4] Legal Action Center, State, Local Welfare Officials See Important Role for Drug and Alcohol Treatment in Welfare Reform," August 1995.

[5] Constance M. Horgan and Helen J. Levine, "The Substance Abuse Treatment System: What Does It Look Like and Whom Does It Serve? Preliminary Findings from the Alcohol and Drug Services Study," in **Bridging the Gap Between Practice and Research: Forging Partnerships with Community-Based Drug and Alcohol Treatment**,, Institute of Medicine, National Academy Press. Washington, DC: 1998.

[6] Patrick H. Hughes, *et. al.*, "Retaining Cocaine-Abusing Women in a Therapeutic Community: The Effect of a Child Live-In Program," *American Journal of Public Health*, Volume 85 (1995), pp. 1149-1152.

[7] Wendy Chavkin, *et. al.*, "National Survey of the States: Policies and Practices Regarding Drug-Using Pregnant Women," *American Journal of Public Health*, Volume 88 (1998), pp. 117-119.

[8] *Ibid.*

[9] *State v. Whitner*, Opinion No. 24468, Filed July 15, 1996.

Challenges Facing Women on Welfare Who Are in Alcohol and Drug Treatment

During site visits, providers and women in treatment brought up a variety of challenges facing women on welfare trying to make the transition into recovery, off welfare, and into jobs. These challenges included:

- Finding clean, sober, and affordable housing.

Some treatment programs are able to offer their clients clean, sober, and affordable housing – such as group recovery homes – nearby when they complete their residential treatment. This housing is critical in helping women make the transition back into community living, and proximity to the treatment program can help facilitate continuing care services, such as AA and NA meetings, that help prevent relapse or facilitate early intervention in case of relapse.

The possibility of losing custody of their children has motivated many women to enter and succeed at treatment... These women will need enough time in treatment to achieve recovery, improve their job skills, and create safe homes for their children.

But not all programs can offer these services. For some, the barrier is funding. For others, the barrier is community opposition and discrimination – the "not in my backyard" (NIMBY) phenomenon – even though treatment programs and recovery homes improve neighborhoods by helping people get well.[45]

Compounding the problem is the overall shortage of affordable housing for low-income renters, which is growing.[46] The shortage is likely to be even more acute for individuals in recovery because recent changes in federal housing law have permitted local housing authorities to exclude individuals with histories of alcohol and drug problems from public housing, including public housing set aside for the disabled.[47]

- Fulfilling requirements from another system, such as the child welfare or criminal justice system, that conflict with treatment or work and work training activities.

The possibility of losing custody of their children has motivated many women to enter and succeed at treatment, and many women in publicly funded treatment are involved with or at risk of becoming involved with the child welfare system because of their alcohol or drug problem. These women will need enough time in treatment to achieve recovery, improve their job skills, and create safe homes for their children.

Yet the 1997 federal adoption law[48] will make it more difficult for them to stay in treatment and not lose their children. The new law sets strict limits on the time available for parents to participate in services that promote family preservation and reunification and increases the speed of the adoption process for children in foster care. This has already resulted in women having their parental rights terminated while in treatment.[49]

- Adapting to "work first" philosophies, which, while popular, can actually work against women in treatment and early recovery.

Many states have adopted "work first" approaches to welfare reform, and "work first" is a guiding principle of the federal welfare-to-work program. A "work first" strategy gen-

erally requires welfare recipients to participate first in structured or semi-structured job search programs before education and training.[50]

But pressure on women to leave treatment before they are ready – whether for jobs or other required activities – can actually sabotage these goals among women struggling in early recovery from alcohol and drug problems, according to treatment providers. Relapse can be easily triggered, for example, by feelings of anxiety about a new job or even by receiving a first paycheck.

- Confronting a lack of willingness among employers to hire women with alcohol and drug histories, criminal records, or both.

Stigma against women with alcohol and drug problems, criminal records, or both can broaden the challenge for women who are making the transition into recovery, off welfare, and into jobs.

Stigma[51] against women with alcohol and drug problems, criminal records, or both can broaden the challenge for women who are making the transition into recovery, off welfare, and into jobs. Increasing numbers of women have become involved in the criminal justice system as a result of alcohol and drug problems. For example, between 1986 and 1991, the percentage of women in state prison for drug offenses increased nearly three-fold – from 12 percent to 32.8 percent.[52]

Despite laws protecting individuals in recovery and sometimes ex-offenders, many employers resist hiring them, citing local economic conditions, lack of job skills and employment histories among job applicants, fears about liability and safety, and institutional policies as their reasons.[53] Some of the providers profiled in this report have tried to overcome these barriers by developing relationships with local employers – both over the years and more recently – to help place treatment clients in jobs. They are nurturing these relationships by making treatment staff available to support both clients and employers in making the transition and intervening early if relapse occurs.

- Affordable, quality child care.

All women trying to leave welfare for work need quality child care that is affordable. But the issue is even more acute for women with alcohol and drug problems, whose children are at greater risk of developing these problems themselves.[54] Leaving these children in poorly supervised settings while their mothers are working could increase the chances that they will become involved with alcohol or drugs.

- Transportation.

Transportation needs of women in recovery from alcoholism and drug dependence are particularly acute in rural areas – and not only for employment. Attending AA and NA meetings, which help many individuals sustain their recovery, is more difficult for women with unreliable transportation or transportation that they have to share with a partner, who may still be using alcohol and drugs and not supportive of their recovery.

Challenges Facing Treatment Programs Serving Women on Welfare and their Children

During site visits, treatment providers discussed several key challenges facing them as they try to provide services to women on welfare. Specific challenges mentioned by providers include:

- Difficulty establishing working relationships with state or local welfare agencies.

While recent changes in federal and state welfare laws could help promote collaboration among the many agencies serving families on welfare, many of the treatment programs profiled here reported that their outreach to state and local welfare agencies had not been as successful as they hoped. This was true even in states that had adopted policies to address alcohol and drug problems among welfare recipients and train caseworkers on these issues.

While recent changes in federal and state welfare laws could help promote collaboration among the many agencies serving families on welfare, many of the treatment programs profiled here reported that their outreach to state and local welfare agencies had not been as successful as they hoped.

Programs in Illinois, outside of Chicago, were an exception, however. They had been working over the last several years to build relationships with social services agencies, as part of a state pilot program to address addiction in the child welfare system. Building those relationships took time, according to program staff, but paid off for the programs and the clients. Similar change may occur over the next several years in the welfare system.

- Difficulty establishing working relationships in welfare-to-work system, including with Private Industry Councils (PICs)/Work Investment Boards (WIBs).

Providers reported even greater difficulty, despite outreach efforts, in connecting with local PICs/WIBs and other welfare-to-work agencies, despite the statutory requirements that these agencies serve individuals "needing substance abuse treatment for employment." This is reflected in the fact that only one of the 20 programs profiled received any welfare-to-work funding passed through a PIC/WIB, and even that program received a minuscule amount (less than 1 percent of its budget).

- Lower than expected numbers of referrals from the state or local welfare agency.

Historically, welfare agencies have not been a significant source of referrals of women into the alcohol and drug treatment system. In 1995, publicly funded treatment programs received only 7.2 percent of their referrals from welfare agencies, compared to receiving nearly one-third (34 percent) from the criminal justice system and one-fifth (21.3 percent) from the clients themselves.[51]

New state welfare laws, many of which require screening of welfare recipients for alcohol and drug problems and referral to treatment, if appropriate, were expected to increase referrals. Yet providers report that this is not happening.

No one knows with any certainty why new identification and referral processes are not meeting expectations, but several factors are likely contributing to the problem. For example, in some places, welfare caseworkers are receiving minimal training but are expected to do the screening and referral in addition to other new responsibilities. This

Joan, who is in her mid-40s, graduated from Crossroads, a program for alcoholic and drug dependent women in Windham, Maine. She had been drinking for many years and was suffering severe physical consequences of her alcoholism as well as being disabled by an accident that left her with recurrent pain and difficulty walking. She completed residential treatment, aftercare, and a lengthy course of outpatient treatment. She is currently studying for an associate's degree and working as paid staff at another treatment program.

can add to documented problems caseworkers are already having managing still large individual caseloads and adjusting to their new responsibilities.[56,57]

A second factor may be that the screening tools states have chosen are not appropriate. Questions have been raised recently in the medical literature, for example, about the validity of standard alcohol assessment tools, including the "CAGE,"[58] in detecting problems consistently among women, particularly women of color.[59,60]

A third factor is the context in which the screening interview takes places and the client's beliefs about how screening positive would affect her benefits, as well as the custody of her children. The 1990s have seen a steady increase in criminal justice and child welfare consequences for maternal drug use.[61]

Sanctions may also play a role. If welfare recipients with alcohol and drug problems are more likely to be sanctioned for not complying with new rules, they may be less likely to be in the pool of recipients being screened.

- Difficulty coordinating treatment, work training, and work requirements.

Providers in Florida, for example, reported that their clients are having trouble complying simultaneously with the treatment and work requirements in state law. In California, providers reported that clients were receiving conflicting information from their welfare caseworkers about treatment and work requirements, although individuals in treatment can be exempt from work requirements under state law.

- Shrinking funding for treatment.

Providers reported facing three key financial challenges to treating women on welfare. First, clients are bringing fewer financial resources into treatment with them. Some clients have been denied TANF and food stamps because of felony drug convictions and others because they were in violation of their parole or probation. One program in Florida, for example, reported a 20 percent decrease in the number of clients eligible for TANF and Medicaid because of sanctions.

Second, some of these programs are grantees of CSAT's Residential Women and Children's (RWC) program, which is ending. Providers in California and Maryland were successful in replacing CSAT funding in their state appropriations process, while others are currently struggling with how to replace those funds.

These losses cannot be easily offset. For example, two Medicaid restrictions also limit available treatment funding. The first is that Medicaid cannot pay for residential treatment because of a long-standing prohibition against covering patients in inpatient mental health settings known as "Institutions for Mental Diseases (IMDs)."[62] The second is that managed care is compromising providers' ability, in some places, to be reimbursed for services provided.[63]

Based on the data and other information collected during this project, as well as a careful literature review, we offer the following five recommendations to increase the likelihood that women on welfare who have alcohol and drug problems will successfully make the transition into recovery, off welfare, and into jobs:

Recommendation #1 – Improve the process for screening welfare recipients for alcohol and drug problems and referring them to treatment by requiring that (1) screening be done by trained alcoholism and drug dependence professionals and (2) individuals needing treatment be referred to existing community-based women's treatment programs.

We recommend that screening be conducted by alcoholism and drug dependence professionals – whether they are co-located in welfare agencies or welfare recipients are referred to them as part of the eligibility process.

Women should be screened when they apply for TANF to determine whether they have an alcohol or drug problem that will prevent them from working and referred to appropriate treatment, if needed. Despite efforts to do screening and referral through welfare agencies in some communities, treatment providers in those communities are not experiencing increases in referrals from the welfare system. Many involved in these processes – in both the welfare and treatment systems – identify a lack of training and time among welfare caseworkers as a significant barrier to success.

To ameliorate the situation, we recommend that screening be conducted by alcoholism and drug dependence professionals – whether they are co-located in welfare agencies or welfare recipients are referred to them as part of the eligibility process. This takes the burden off welfare caseworkers. Local women's treatment programs, the state treatment provider association, or the state alcohol and drug abuse agency can help identify individuals to perform the screening, as well as potential sources of funding for it.[64]

If this is not possible, welfare caseworkers should receive adequate training to fulfill these responsibilities, as well as support within their agency for fulfilling them. Ideally, training should not only teach caseworkers how to administer the screening but also improve their level of knowledge, understanding, and sensitivity about addiction and recovery, including the disease model of addiction, which anticipates possible relapse and how to handle it, and allows caseworkers to explore their own comfort and concerns about individuals with addiction problems.[65]

Regardless of who does the screening, women needing treatment should be referred to programs that can meet their unique needs. Welfare agencies should refer these clients to existing treatment programs in the community that serve low-income pregnant and parenting women. A local women's treatment program, the state association of alcohol and drug treatment and prevention providers, and the state alcohol and drug agency can help compile a referral list, as well as identify the resources needed to support and expand these services.

Recommendation #2 -- Close the treatment gap in the alcohol and drug treatment system serving pregnant and parenting women by (1) expanding Medicaid coverage for treatment (a shared Federal and state responsibility), (2) increasing appropriations for the Substance Abuse Block Grant and CSAT's Targeted Capacity Expansion program (a federal responsibility), (3) opting out of or narrowing the 1996 federal welfare law's ban on eligibility for individuals with drug felony convictions (a state responsibility), and (4) using TANF funds for treatment (a state responsibility).

Adequately funding treatment, particularly gender-specific treatment, will be key to improving the lives of welfare families affected by addiction. The Federal and state governments can take steps together and separately to accomplish this goal.

Adequately funding treatment, particularly gender-specific treatment, will be key to improving the lives of welfare families affected by addiction. The Federal and state governments can take steps together and separately to accomplish this goal.

Federal efforts should focus on increasing treatment funding through both entitlement and discretionary programs. Improving entitlement spending would mean expanding Medicaid coverage for treatment. This could be easily accomplished by lifting the prohibition against Medicaid funding of residential treatment services for alcohol and drug problems. Amending current Medicaid regulations, which define alcohol and drug problems as "mental diseases," would remove the "IMD exclusion," one of the greatest barriers to Medicaid funding of alcohol and drug treatment for women.

Improving discretionary spending would require increasing appropriations for two key CSAT programs – the Substance Abuse Block Grant and Targeted Capacity Expansion (TCE). The Block Grant, funded at $1.585 billion in FY 99, is the main source of federal funding for alcohol and drug treatment and requires states to maintain FY 1994 levels of spending for women's services. TCE, created by the FY 99 appropriations law, provides $16 million in FY 99 "to compliment [sic] existing and previously planned targeted HIV/AIDS minority activities to strengthen treatment and prevention programs that include an HIV component," $9 million of which is set aside for alcohol and drug treatment for women and their children.[66]

States should take three key actions to improve treatment funding for women on welfare. First, they should expand their Medicaid plan's coverage of treatment. Many states do not cover a comprehensive array of treatment services in their Medicaid plans. A 1997 study of state alcohol and drug abuse directors reported that only 10 states (out of 33 responding) provided comprehensive coverage, including outpatient, non-hospital residential, hospital-based, and methadone maintenance services.[67]

Second, states should opt out of or narrow the 1996 federal welfare law's ban on eligibility for TANF and food stamps for individuals with drug felony convictions. More than half (26) have done so. Nearly one-fifth (8) of states have opted out entirely, and more than one-third (18) have opted to narrow the ban. A popular approach to narrowing the ban is to exempt, among others, individuals who are in treatment, which gives the woman an incentive to enter and stay in treatment and protects the funding available to treatment programs to pay for services.

Third, states should take advantage of their flexibility to invest TANF funds in alcohol and drug treatment for welfare recipients. The main limitation to this flexibility is that federal TANF funds may not pay for medical services, but many treatment services, such as individual and group counseling, are not medical in nature. States may use their maintenance of effort (MOE) funds for treatment services, including medical services such as dosing and dispensing of methadone, as long as those funds are not commingled with federal TANF dollars.

Recommendation #3 – Improve coordination between treatment and other requirements imposed on women by welfare, welfare-to-work, and other public systems, allowing them adequate time to achieve recovery and put their lives back together before sanctioning them or terminating their benefits.

States should take advantage of their flexibility to invest TANF funds in alcohol and drug treatment for welfare recipients.

Low-income women with alcohol and drug problems bring multiple problems and legal requirements into treatment with them, including those imposed by a drug court, a correctional agency (including probation or parole), and the welfare and child welfare systems. These systems can have different expectations about how these clients should fulfill the requirements. These differences can limit the time and attention they can devote to their recovery. But without recovery, some of these women will not succeed at the other requirements, including work training and work, taking care of their children, and rehabilitation and restitution.

The multiple systems involved in these women's lives need to collaborate to ensure that, at a minimum, their requirements do not work at cross purposes. Activities to facilitate collaboration could include designating staff liaisons to communicate information across agencies, formal cross-agency advisory groups, and cross-training of staff.[58] Community-based private agencies serving these clients, such as alcohol and drug treatment programs, should also be involved in the collaborative process, where possible and appropriate.

Recommendation #4 – Study the results of state welfare policy choices in terms of (1) their impact on families on welfare affected by addiction, (2) their effectiveness and cost-effectiveness, and (3) their effects on the alcohol and drug treatment system as it serves welfare recipients. Results of these studies should be widely disseminated.

Numerous government agencies and private organizations are collecting data and other information to try to understand the effects of the 1996 federal welfare law (and subsequent state laws) on families receiving welfare. Few, if any, of these studies have yet examined the law's effects on uniquely vulnerable subgroups of welfare recipients, including those with alcohol and drug problems.

States have taken a variety of approaches to identifying welfare recipients with alcohol and drug problems and referring them to treatment, but relatively little research has

examined which are the most effective and cost-effective. States will need this information to improve their programs over time. Research should focus on, among other issues, the mix of clinical and supportive services that are most effective at helping women make the transition into recovery, off welfare, and into jobs that help them support their families.

Recommendation #5 – Implement what works best.

The programs profiled in this report have been helping pregnant and parenting women make the transition into recovery, off welfare, and into jobs for many years. Their models – described here – have helped thousands of women acquire vocational skills and jobs while learning to live without alcohol and drugs and be better parents.

The programs profiled in this report…have helped thousands of women acquire vocational skills and jobs while learning to live without alcohol and drugs and be better parents.

The key to success is to provide alcoholic and drug dependent women on welfare with adequate time to focus on treatment and recovery (particularly early recovery), training (including literacy, GED, and vocational services) tailored to their individual needs, and supportive services (including child care, transportation, and clean and sober housing). These successful programs also maintain relationships with their graduates through support groups and access to care in the event of relapse, as well as local employers to help the transition into jobs work for all involved.

Carol, age 30, used heroin and cocaine for16 years. As a runaway teen, she turned to prostitution to support herself financially. She sought help in a group for battered women and accepted the suggestion to get help for her drug abuse as well. Highly motivated, she has used outpatient services at Prototypes Women's Center in Pomona, California, to support major changes in her life. She has enrolled in college and secured a part-time job on campus. She is excited about the future and committed to remaining in outpatient treatment.

Work Models That Work

Work and work training are integral parts of many alcohol and drug treatment programs for women with children. As clients progress in their recovery, many receive educational and job readiness services and begin to work within the structured environment of the treatment program. Here are some examples from the programs profiled in this report.

- After an assessment of educational and vocational skills, clients at Center Point in San Rafael, California, begin formal work training modules, which last 12 weeks, that help prepare them to enter the job market. Staff support client employment goals by operating a job bank that includes 150 employers and networking with local businesses. Staff also are available to help clients make the transition into the job. This helps assure employers that treatment and training staff can intervene with a client who is at high risk of relapsing or who has relapsed. Community integration groups – providing post-employment support on such issues as job retention, money management, and credit – are also available to treatment clients and graduates.

- Prototypes Women's Center in Pomona, California, operates a multifaceted on-site work training program. When the women are ready (usually after about a month in treatment), they choose among five training tracks – retailing, word processing, culinary arts, child care, or receptionist/office work. Each track lasts 12 weeks, with clients spending four hours a day/three days a week on the training activity. Clients are evaluated after six weeks of training and again after 12 weeks. Clients also accumulate work experience in their chosen training track by working in Prototypes' kitchen or thrift shop, for example.

  After they have satisfactorily finished a module, they receive a certificate of completion, help with describing the experience on their resume, and a $50 certificate toward interview clothing. If they wish to continue their training, they can choose to repeat a module or receive training in one of the other four areas.

- Clients at Rosecrance in Rockford, Illinois, gain work and work training experience both on- and off-site, including by performing tasks at the treatment program. In mid-1998, Rosecrance bought and opened a shrink wrapping plant, where clients can gain work and work training experience. Training programs at the local Goodwill Industries are also available to clients. Rosecrance clients can also work toward their education through an on-site GED program, which meets on Tuesdays and Thursdays.

- At the Center for Addiction and Pregnancy in Baltimore City, Maryland, clients are assessed for their academic and job skills, which inform their work and work training placements. They are "hired" to work at the program, performing activities that are appropriate to their skills level. For example, if a training client has no reading skills, her first training activity would be learning to read. Other clients, with more skills, do data entry and office work. Clients are paid – in the form of vouchers, which the women can use toward rent, groceries, furniture, and other items – for every day they work a shift and test negative for drugs.

- Amethyst, in Columbus, Ohio, qualifies as a certified job site under the county's Department of Human Services rules. Work that clients perform at the program helps satisfy their TANF work requirements. Staff are currently in the process of forging a partnership with a new work training program in the community and relationships with local employers.

Conclusion

Changes in federal, state, and local welfare laws and policies have created real opportunities for addressing alcohol and drug problems among low-income women with children. Many states and localities are currently struggling with how to take advantage of those opportunities. Failure could come at a high cost – both for the families, which could face dissolution, and for state and local governments, which could have to support these individuals and families without federal assistance.

A number of welfare recipients with alcohol and drug problems will need treatment to be able to make the transition into recovery, off welfare, and into jobs. Many will also face other barriers to employment, including histories of domestic violence, mental health problems, and limited education and vocational skills, which could make the transition even more difficult.

Building and sustaining relationships across the variety of public and private agencies charged with the welfare of families, particularly families affected by addiction, will be a challenge.

Over the last 10 to 20 years, treatment programs serving pregnant and parenting women have developed models for addressing the multiple problems of women with alcohol and drug problems, as well as providing prevention and early intervention services for their children. These resources are available to state and local welfare agencies in many communities.

Building and sustaining relationships across the variety of public and private agencies charged with the welfare of families, particularly families affected by addiction, will be a challenge. Meeting the challenge will require creativity, increased funding for treatment services, collaboration, and attention to the intended and unintended effects of the policies adopted to address addiction among welfare recipients.

Endnotes

[1] P.L. 104-193, "The Personal Responsibility and Work Opportunity Reconciliation Act of 1996."

[2] A. Woodward, et. al., "The Drug Abuse Treatment Gap: Recent Estimates." *Health Care Financing Review*, Volume 18 (1997), pp. 5-17.

[3] In the case of some welfare recipients with alcohol and drug problems, work requirements will have to be coordinated with criminal justice system requirements as well as treatment requirements.

[4] U.S. General Accounting Office, *Welfare Reform: States Are Restructuring Programs to Reduce Welfare Dependence*, June 1998.

[5] Laura Schmidt, *et. al.*, "Substance Abuse and the Course of Welfare Dependency," *American Journal of Public Health*, Volume 88 (1998), pp. 1616-1622.

[6] For possession, use, or distribution where both the conduct and the conviction occurred after August 22, 1996.

[7] Michigan is only the second state to enact such a requirement. The first, Louisiana, is not actually implementing a testing program. Instead, the state is using a 20-question screening instrument.

[8] The final rule implementing the TANF program explicitly allows states to use federal TANF funds for alcohol and drug treatment (64 FR 17840) (as long as the services are non-medical) as well as their own welfare funds (64 FR 17830).

[9] Created in Title V of "The Balanced Budget Act of 1997" (P.L. 105-33) and appropriated $3 billion for Fiscal Years 1998 and 1999.

[10] Under the Workforce Investment Act of 1998 (P.L. 105-220).

[11] Section 403(a)(5)(C)(ii)(I)(bb).

[12] Summarized Highlights of Proposed Draft Regulations, October 22, 1997.

[13] Section 408(a)(6) of the Social Security Act.

[14] U.S. General Accounting Office, "Welfare Reform: Status of Awards and Selected States' Use of Welfare-to-Work Grants," February 1999, p. 2.

[15] The remainder is set aside for Indian tribes, evaluation, and performance bonuses for states.

[16] "Welfare-to-Work Competitive Grants," *Federal Register*, January 26, 1999, pp. 4009-4023.

[17] Laura Meckler, "Welfare Roll Numbers Hit 30-Year Low," *The Washington Post* (via Associated Press), January 25, 1999, p. A4.

[18] Data from the Administration for Children and Families web site.

[19] Reported through the National Governors' Association, National Conference of State Legislatures, and American Public Human Services Association. Results cited from the NGA website.

[20] U.S. General Accounting Office, "Welfare Reform: States Are Restructuring Programs to Reduce Welfare Dependence," June 1998, p. 4.

[21] Substance Abuse and Mental Health Services, *Substance Use Among Women in the United States*, 1997, p. 2-18.

[22] National Institute on Drug Abuse, "National Pregnancy and Health Study," September 1994.

[23] U.S. Department of Health and Human Services, "Substance Abuse Among Women and Parents," July 1994, p. iii.

[24] Studies by: Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (1994); National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health (1996); and National Center on Addiction and Substance Abuse at Columbia University (1995).

[25] Legal Action Center, *Making Welfare Reform Work: Tools for Confronting Alcohol and Drug Problems Among Welfare Recipients*, September 1997, pp. 38-39.

[26] Data were from the former Aid to Families with Dependent Children (AFDC) program.

[27] U.S. Department of Health and Human Services, "Patterns of Substance Use and Substance-Related Impairments Among Participants in the Aid to Families with Dependent Children Program (AFDC)," December 1994.

[28] Bridget F. Grant and Deborah A. Dawson, "Alcohol and Drug Use, Abuse, and Dependence Among Welfare Recipients," *American Journal of Public Health*, Volume 86 (1996), pp. 1450-1454.

[29] Substance Abuse and Mental Health Services Administration, *National Admissions to Substance Abuse Treatment Services – The Treatment Episode Data Set (TEDS), 1992-1996*, 1998, p. 9.

[30] National Association of State Alcohol and Drug Abuse Directors, *State Resources and Services Related to Alcohol and Other Drug Problems for Fiscal Year 1994*, 1996, p. 23.

[31] Ibid., p. 68.

[32] Vicki Breitbart et. al., "The Accessibility of Drug Treatment for Pregnant Women: A Survey of Programs in Five Cities," *American Journal of Public Health*, Volume 84 (1994), pp. 1658-1661.

[33] A. Woodward, op. cit.

[34] Substance Abuse and Mental Health Services Administration, op. cit., page 6-13.

[35] Dean R. Gerstein et. al., "Alcohol and Other Drug Treatment for Parents and Welfare Recipients: Outcomes, Costs, and Benefits." U.S. Department of Health and Human Services, 1997.

[36] Center for Substance Abuse Treatment, "Women In Treatment," National Treatment Improvement Evaluation Study, 1997.

[37] Unpublished data from the Center for Substance Abuse Treatment.

[38] Data are for 1,555 women served between April 1995 and September 1996. Follow-up occurred from one to 18 months after treatment completion.

[39] Data are for 335 women for whom post-discharge information was available as of September 1996 and who had been treated between January 1993 and September 1997. Follow-up was between one to 18 months after treatment completion.

[40] U.S. Department of Health and Human Services, *Services Research Outcomes Study*, 1998, pp. III-29-39.

[41] Obviously, resources limited the number of programs we could visit.

[42] With one exception – we did not visit Crossroads for Women.

[43] Funds services for individuals with HIV/AIDS or at risk of HIV/AIDS.

[44] Section 508 of the Public Health Service Act.

[45] Center for Substance Abuse Treatment, *Siting Drug and Alcohol Programs – Legal Challenges to the NIMBY Syndrome (TAP #14)*, 1995.

[46] Center on Budget and Policy Priorities, "In Search of Shelter – The Growing Shortage of Affordable Rental Housing," June 1998.

[47] An example is P.L. 104-120, the "Housing Opportunity Program Extension Act of 1996," which permits housing authorities to exclude individuals who have had past alcohol and drug problems on the basis of little evidence of an on-going threat or risk to other tenants.

[48] "The Adoption and Safe Families Act" (P.L. 105-89).

[49] Personal communication from treatment providers in Oregon.

[50] Pamela A. Holcomb, *et. al.*, "Building an Employment Focused Welfare System," The Urban Institute, June 1998.

[51] An excellent discussion of these issues – from the perspective of women who have had these experiences – appears in: Susan Galbraith, *And So I Began to Listen to Their Stories: Working With Women in the Criminal Justice System*, The National GAINS Center for People with Co-Occurring Disorders in the Justice System, 1998.

[52] Tracy L. Snell, "Women in Prison, Survey of State Prison Inmates, 1991," U.S. Department of Justice, March 1994.

[53] Debbie Mukamal, "Criminal Histories as a Barrier to Employment: A Report for the Annie E. Casey Foundation," Summer 1997, unpublished.

[54] Institute of Medicine, *Pathways of Addiction: Opportunities in Drug Abuse Research*, 1996, pp. 119-120.

[55] Constance M. Horgan and Helen J. Levine, "The Substance Abuse Treatment System: What Does It Look Like and Whom Does It Serve? Preliminary Findings from the Alcohol and Drug Services Study," in *Bridging the Gap Between Practice and Research: Forging Partnerships with Community-Based Drug and Alcohol Treatment*, 1998.

[56] Janet Looney and Betty Jane Narver, "Meeting the Goals of Washington's Work First Program: Key Policy Challenges." In: Federalism Research Group, The Nelson Rockefeller Institute of Government, State University of New York, *Managing Welfare Reform: Updates from Field Research in Five States*, January 1999.

[57] Jeanette M. Hercik, "At the Front Line: Changing the Business of Welfare Reform," Welfare Information Network, May 1998.

[58] A four-question instrument chosen by several states that attempts to determine whether those being screened have ever felt that they should cut (C) down on their drinking, been annoyed (A) by others criticizing their drinking, felt guilty (G) about their drinking, or have had to have an "eyeopener" (E) in the morning to steady their nerves or get rid of a hangover.

[59] J. R. Steinbauer, et. al., "Ethnic and Sex Bias in Primary Care Screening Tests for Alcohol Use Disorders," *Annals of Internal Medicine*, Volume 129 (1998), pp. 353-362.

[60] Katherine A. Bradley, "Alcohol Screening Questionnaires in Women," *Journal of the American Medical Association*, Volume 280 (1998).

[61] Wendy Chavkin et. al., "National Survey of the States: Policies and Practices Regarding Drug-Using Pregnant Women," *American Journal of Public Health*, Volume 88 (1998), pp. 117-119.

[62] The IMD exclusion prohibits Medicaid for paying for any services delivered to individuals between the ages of 22 and 64 in a residential treatment facility with more than 16 treatment beds.

[63] Programs in Chicago and Maryland expressed the most concern about this problem.

[64] This has been successful in Oregon.

[65] Sacramento County has been experimenting successfully with this approach.

[66] House Report 105-825, "Making Omnibus Consolidated and Emergency Supplemental Appropriations for Fiscal Year 1999," pp. 1281-1282.

[67] Legal Action Center, op. cit., p. 39.

[68] Amy Johnson and Alicia Meckstroth, "Ancillary Services to Support Welfare-to-Work," Mathematica Policy research, Princeton, New Jersey, 1998, p. 195.

AA/NA (Alcoholics Anonymous and Narcotics Anonymous) – 12-step, self-help programs for individuals in recovery.

ASAM – American Society of Addiction Medicine is an international medical specialty society of physicians from all areas of medicine concerned about alcohol, nicotine, and other drug dependence who are engaged in prevention, treatment, research, and education on these issues. ASAM has developed and published placement criteria to guide decisions about the appropriate level of care for a treatment client.

ASI – Addiction Severity Index, a screening instrument used to determine the intensity and progress of individual's alcohol or drug problem. The ASI assesses patient functioning in seven major life domains – medical, employment, alcohol and drugs, legal, family/social, and psychological – often affected by substance abuse. The ASI provides detailed information on recent (past 30 days) and past patterns and severity of drug and alcohol use.

CSAT – Center for Substance Abuse Treatment. The part of SAMHSA responsible for administering federal alcohol and drug treatment programs, such as the Substance Abuse Prevention and Treatment Block Grant.

CSAP – Center for Substance Abuse Prevention. The part of SAMHSA responsible for administering certain federal alcohol, drug, and tobacco prevention programs, such as programs targeting prevention services at youth living in high-risk environments.

DSM-IV – The *Diagnostic and Statistical Manual* of the American Psychiatric Association (fourth edition). The DSM is a standard reference for diagnosing mental and addictive disorders.

NHSDA – National Household Survey on Drug Abuse, an annual survey on trends in alcohol, drug, and tobacco use in the non-institutionalized U.S. population. The survey is a random sample representing 98 percent of U.S. households.

Relapse – Relapse is common in recovery from addiction and not considered treatment failure. As with other chronic illnesses (such as diabetes and hypertension), significant improvement is considered successful treatment even if complete remission or absolute cure is not achieved.

SAMHSA – Substance Abuse and Mental Health Services Administration. Part of the U.S. Public Health Service in the Department of Health and Human Services, SAMHSA is responsible for administering federal alcohol, drug, and mental illness treatment and prevention programs.

TANF – Temporary Assistance for Needy Families. Created in 1996, TANF combines the former programs of Aid to Families with Dependent Children (AFDC), Job Opportunities and Basic Skills (JOBS), and Emergency Assistance (EA). Grants go to states, not individuals.

Therapeutic community (TC) – Therapeutic communities, pioneered in the 1950s, view alcohol and drug problems as disorders of the whole person in which alcohol and drug use is combined with impaired functioning, cognitive and behavior problems, and other manifestations of an anti-social lifestyle. Mutual self-help is a critical dynamic in the TC therapeutic process. TCs generally consist of a highly structured family environment that emphasizes honesty, trust, and self-help. In addition to daily seminars, group counseling, and individual activities, clients are assigned house responsibilities, such as kitchen, maintenance, procurement, and reception duties.

12-Step or Self-Help Programs – See AA/NA.

CALIFORNIA

Center Point Women & Children's Program
809 B Street
San Rafael, California 94901
415-459-2395

Executive Director: Sushma Taylor

About the Center Point Women & Children's Program

Center Point's Women & Children's Program is a residential alcohol and drug treatment program for pregnant and post-partum women and their children. Center Point is a multifaceted, nonprofit alcohol and drug treatment agency that has served the San Francisco Bay area since 1971.

Center Point's target population is Latina and Native American women with alcohol and drug problems.

The main goals of the program are to: (1) reduce alcohol and drug use and the related physical and psychosocial stressors that affect women with children by providing comprehensive residential treatment and (2) assist pregnant and post-partum women in achieving economic and social self-sufficiency by social skills training, education, vocational services, and access to housing and human services for them and their children.

All clients are pregnant or post-partum (up to 52 weeks) women and their children. The average woman enters treatment with one child and stays for 120 days after having been referred from a Welfare, child Welfare, public health, or criminal justice agency. Clients are predominantly under the age of 30 and have never been married.

Center Point's target population is Latina and Native American women with alcohol and drug problems. Currently, Latina and Native American women make up 40 percent of Center Point's clientele.

Treatment Services

The program can accommodate a total of 40 women and children at one time in residential treatment, and the average client does not have to wait for a treatment slot to open. Services are available for up to 12 months.

Screening and assessment. Women receive in-depth assessment of their problems, needs, and strengths. Clinical screening is conducted with a variety of instruments, including the Personality Assessment Inventory (PAI), Adolescent Severity Addiction Profile-Biopsychosocial (ASAP-BP), and Substance Abuse Problem Checklist (SAPC).

Outpatient services are available as an alternative to residential services for clients who are in the early or middle stage of addiction.

Residential services are provided in a therapeutic community setting. Clients stay in one of seven bungalows, where they can live with their children during treatment. Each

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bungalow has a fully equipped kitchen, with shared laundry facilities and a child development center.

Other available services include perinatal and medical care (such as tuberculosis and HIV education, counseling, and testing), individual, group, and family counseling and psychotherapy.

In-treatment support services include child care, transportation, clean and sober housing, exit planning, and parenting training. Children receive a range of services, including developmental and cognitive assessment, age appropriate play therapy, socialization, self-esteem enhancement, and skills development.

Work and work preparation activities are heavily emphasized at the program, with centralized training facilities serving clients in many Center Point programs.

Formal work training modules that help prepare clients to enter the job market last 12 weeks. In conjunction, clients participate in discussion groups that focus on issues that arise about job interviewing.

The first step for clients is an assessment of their educational and vocational skills, with plans for how to meet identified needs and incorporate them into a client's overall treatment plan. Needs identified often include tutoring to prepare for high school equivalency (GED) testing or other adult education.

Formal work training modules that help prepare clients to enter the Job market last 12 weeks. In conjunction, clients participate in discussion groups that focus on issues that arise about job interviewing.

Center Point staff also support client employment goals by operating a job bank that includes 150 employers. Staff also network with local businesses and make themselves available to help clients make the transition into the job. This helps assure employers that treatment and training staff can intervene with a client who is at high risk of relapsing or who has relapsed. Center Point also offers community integration groups, which provide post-employment support to clients on such issues as job retention, money management, and credit.

Aftercare and support services are offered to help clients re-enter the community, including transitional clean and sober housing – a total of 40 beds for up to 24 months. Staff also help develop job and housing networks for individuals in recovery and periodically follow-up with program graduates to record progress and change in their lives.

Funding for Treatment

Two main sources currently support treatment services at Center Point's Women & Children's Program – federal categorical funding from CSAT (65 percent) (through the Pregnant and Postpartum Women & Children's program) and match money raised by the program from in-kind contributions, foundations, and state and local sources (35 percent). Vocational training services are supported, in part, by funding from the Job Training Partnership Act.

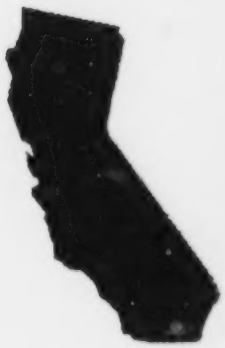
Evaluation & Client Outcomes

Between March 1996 and December 1998, the program served 95 women. At the time of intake, 65 percent had not completed high school, and 97 percent were living below the poverty line and were unemployed.

S. entered residential treatment at the Rural Women's Recovery Program in Athens, Ohio, after a divorce and after she began using drugs and alcohol to cope with being a single parent to her two small children. She was experiencing all of the consequences of an addictive lifestyle. Her former in-laws accused her of not caring for her children adequately, she faced legal charges associated with her drug use, and she was not paying her bills, which meant she was going to be evicted from her apartment. She checked herself into treatment at the age of 22. She obtained a job at Hardees and works several hours, as required by the Department of Human Resources, to maintain her welfare eligibility. As the level of alcohol and drug use in her life decreased, she had to face the memories of past sexual abuse from her grandfather. S. has enrolled in nursing school and takes her children to church, which she also attends when her work schedule allows. She also attends AA/NA meetings when her work schedule allows.

All of the women (100 percent) who completed treatment were either employed or enrolled in school or training full-time at discharge, in comparison with less than one-third of women who did not complete the program.

According to Center Point training staff, it generally takes clients less than five days to find jobs. In mid-1998, clients were making an average of $8.78 per hour, up from $8.21 earlier in the year.



All of the women (100 percent) who completed treatment were either employed or enrolled in school or training full-time at discharge, in comparison with less than one-third of women who did not complete the program.

Project Pride
East Bay Community Recovery Project
2551 San Pablo Avenue
Oakland, California 94607
510-893-3733

Project Director: Kimberly Harrell

About Project Pride

Project Pride is a five-year-old residential alcohol and drug treatment program for pregnant and post-partum women and their children. It is affiliated with East Bay Community Recovery, which is a multifaceted, nonprofit alcohol and drug treatment agency that serves the San Francisco Bay area.

The program operates in a context of mutual support, enabling women to be responsible for themselves, their families, and their community.

The main goal of the program is to empower women with children in a safe environment by promoting personal responsibility, emotional growth, positive parenting skills, and recovery from alcohol and drug problems. The program operates in a context of mutual support, enabling women to be responsible for themselves, their families, and their community.

Project Pride serves 15 clients at a time, all of whom are pregnant or post-partum women and their children. The average woman enters treatment with two children (under the age of 12) and stays for 270 days after having been referred by the child Welfare system or the local parole or probation agency. Clients wait an average of 30 days for a treatment slot to open.

Almost all (85 percent) have neither a high school diploma nor GED certificate. Most (90 percent) are chronically unemployed, and more than half (60 percent) have limited reading ability. A little less than half of the women (40 percent) have a mental illness in addition to their alcohol or drug problem, and a few (3 percent) are also HIV positive.

Treatment Services

Screening and assessment. Women are screened using the Addiction Severity Index (ASI).

Outpatient services are available on an interim basis to women who have to wait for a residential treatment slot to become available.

Residential services include individual, group, couple, and family counseling. On-site AA/NA meetings are also available. Services focus on personal development, awareness and growth, and the ability to work with others.

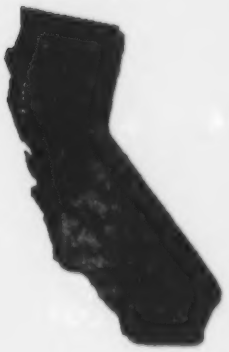
In-treatment support services include child care, exit planning, and parenting education.

Clients also receive on-site help for addressing their mental health problems, including psychotherapy, access to psychotropic medications, and acupuncture. Medical care is also available, including screening and testing for tuberculosis, HIV, and pregnancy.

Case management helps the women use medical, social services, and education and training resources to their advantage.

Children's services include therapeutic child care and enhanced play groups for children at different developmental stages. A child enrichment team also provides children between the ages of 5 and 12 with specialized individual attention. School-age children leave for school in the morning and participate in an ongoing homework group at the program in the afternoon. Children too young to attend school stay with child enrichment workers and their mothers while the other children are at school. Individual counseling is also available to children assessed as needing it.

Work and work preparation activities are required as part of treatment and occur concurrently with treatment, with special emphasis in the final phases of treatment. Clients can engage in work and work training both on- and off-site. Clients are referred to literacy and GED preparation classes in the community.



Clients can engage in work and work training both on- and off-site.

Aftercare and support services include assistance in locating clean and sober housing, referrals for family therapy, home visits by staff and current residents, urine drug testing, continued medical care, and case management. Graduates may also return to the program if they need support for their continued stability and recovery.

Program graduates are also encouraged to attend a weekly aftercare group and keep in touch with their primary counselor after leaving the program. They are also invited to special holiday celebrations at the program.

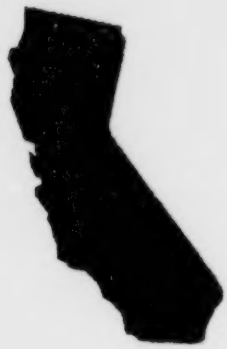
Funding for Treatment

Four main sources of funding support treatment services at Project Pride – categorical funding from CSAT (60 percent), TANF (4 percent), food stamps (2 percent), and the criminal/juvenile justice system (34 percent).

Evaluation & Client Outcomes

Data were collected on a sample of 84 former clients using a variety of sources, including staff knowledge questionnaires and follow-up with individual women. Results include:

- Abstinence (data available on 48 women) – 30 (63 percent) remained abstinent after leaving treatment while 18 (37.5 percent) had relapsed to using alcohol or drugs.
- Job (data available on 45 former clients) – 22 (48.9 percent) were working at a regular job or enrolled in educational or vocational training.
- Child custody (data available on 53 women) – 42 (79.2 percent) had custody of at least one of their children after treatment.
- Public assistance (data available on 47 women) – 25 (53.2 percent) were currently receiving some form of public assistance, including TANF, Supplemental Security Income/Disability Income, Medicaid, and military/veterans health benefits.



La Casita de las Mamas
10503 Downey Avenue
Downey, California 90241
562-622-2268

Program Director: Peggie L. Van Fleet

About La Casita

La Casita is a bilingual, bicultural residential alcohol and drug treatment program serving women with children. It opened in March 1996 to provide culturally competent treatment services to Latina mothers in Los Angeles County.

La Casita is part of a large, multifaceted treatment agency – Southern California Alcohol & Drug Programs – whose subagencies serve greater Los Angeles and Orange counties. Programs under the SCADP umbrella offer more than 350 residential treatment beds, 1,200 outpatient counseling slots, drinking driver education, information, and referral, prevention programs for adolescents, and case management services.

On-site employment and career planning is a six-week process where women meet one-on-one with a career counselor and use a curriculum developed by a re-entry specialist from a local college.

La Casita can accommodate 15 women and 15 children. Nearly all of the women served there are addicted to both alcohol and drugs (97 percent), have a history of previous treatment and relapse (80 percent), and have not graduated from high school (83 percent). About one-sixth (16 percent) have a co-occurring mental illness, and 3 percent have been victims of domestic violence. The average woman enters La Casita with three children and stays for six months after having been referred from a welfare, child welfare, public health, or private health care agency.

Treatment Services

Women at La Casita receive residential treatment for six months. Children between the ages of 1 and 11 are welcome to be in treatment with their mothers.

Screening and assessment. Clients are screened using the Addiction Severity Index (ASI).

Outpatient services are available through other local SCADP agencies, including at Bell Gardens, Los Angeles, and Downey.

Residential services. A comprehensive array of services is available at La Casita, including group counseling, 12 Step groups, and individual therapy. Group counseling focuses on drug and alcohol education (such as relapse prevention), women's issues (such as relationships), and life skills (such as communication skills). The sessions are ongoing throughout the six months women stay at La Casita. Each group lasts 90 minutes and is facilitated by a program therapist, who directs the content and flow.

In-treatment support services. Clients receive child care and transportation during treatment. The program also emphasizes parenting training, which is conducted over 12 weeks in 90-minute sessions and focuses on improving relationships within the family.

Children receive an array of services, including group sessions, tutoring, and individual counseling, including participation in the nationally recognized Children of Drug Abusers and Alcoholics (CODA) program.

Work and work preparation activities. La Casita offers many job planning, training, and preparation services – both on- and off-site – to clients. On-site employment and career planning is a six-week process where women meet one-on-one with a career counselor and use a curriculum developed by a re-entry specialist from a local college. Individual sessions explore the client's areas of interest and/or previous employment and education, aptitude testing, career goal planning, resume writing, and interviewing skills.

Off-site, clients can participate in job training and placement services, including an18-month-old Job Club, through SCADP. SCADP skills classes available to La Casita clients take place in 12-week cycles and focus on interviewing, writing a resume, and re-entry into the work force. La Casita routinely links clients with literacy and GED preparation classes in the community. Clients also have access to federal Job Training Partnership Act-funded services through local community colleges. SCADP will also provide participants with employer advocacy on the job to resolve issues that may come up for newly employed women in recovery.

SCADP will also provide participants with employer advocacy on the job to resolve issues that may come up for newly employed women in recovery.

SCADP is working toward integrating work and work training into all of its programs, starting with computer and remedial math and English classes. SCADP currently operates a vocational rehabilitation facility available to La Casita clients, but clients must get there to receive services.

Aftercare and support services. Counseling and support services are available to clients who graduate from La Casita, as is assistance in finding clean and sober housing after treatment.

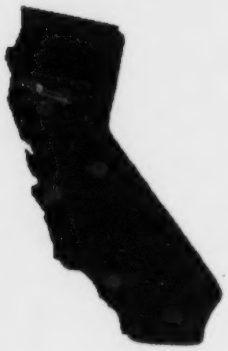
Funding for Treatment

La Casita accepts clients regardless of their ability to pay, and public funding supports almost all of the women enrolled. Almost all of La Casita's funding (95 percent) is from the Center for Substance Abuse Treatment's (CSAT) Residential Women with Children program. TANF funding (3 percent), food stamps (2 percent), and client payments (1 percent) make up the rest of the funding support.

Evaluation and Client Outcomes

Outcome data are currently available for two cohorts of graduates of La Casita. Findings include:

- Among the second cohort, 10 of the 11 graduates were abstinent from alcohol and drugs after 12 months, for an abstinence rate of 91 percent.
- Among the first cohort, four graduates had relapsed at six-month follow-up, for an abstinence rate of 63.6 percent.



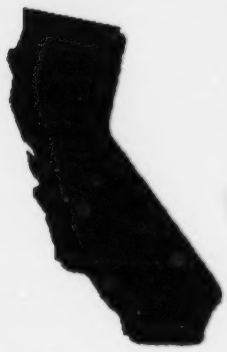
- Among the 12 graduates who were mandated to attend treatment by child protective services, all had positively resolved child custody issues at both six and 12 months after treatment.
- Program graduates showed statistically significant improvements in their ability to deal with their children in a more positive manner than a comparison group of outpatient graduates.
- Program graduates reported a statistically significant lower level of parental stress than a comparison group of outpatient graduates after six months.
- Participating children between the ages of one and five years showed improvement in fine motor skills, gross motor skills, and personal/social behavior, with more than 90 percent scoring within a normal range at program exit.
- Nearly 40 percent of graduates at intake were actively involved with partners with alcohol and drug problems. At treatment discharge, the number was 20 percent; at six-month follow-up, it was 10 percent. None of the graduates assessed at 12 months after treatment was involved with a partner with alcohol and drug problems.

Among the 12 graduates who were mandated to attend treatment by child protective services, all had positively resolved child custody issues at both six and 12 months after treatment.

Before entering residential treatment at La Casita, K. says that she lived to use drugs and used drugs to live and that she lost her sanity, her son, and her self-respect. At La Casita, she learned how to function, develop relationships, and share her lives with others. She regained custody of her son and owns a car. She is looking forward to going back to school.

Patterns Women with Children Recovery Program
12917 Cerise Avenue
Hawthorne, California 90250
310-675-4431

Program Director: Chynethia Leake



About the Patterns Women with Children Recovery Program

Patterns is a long-term residential recovery program for alcohol and drug dependent women and their children. It is part of Behavioral Health Services (BHS), a comprehensive Los Angeles-based alcohol and drug treatment agency. Patterns provides a structured residential program where family reunification for addicted women and their children can occur with respect for the mother, the child, and the family bond.

Patterns's philosophy is that recovery is a life-long process that is most successful when it begins in a stable, supportive, community environment over an extended period of time. Using this philosophy, Patterns tries to mend the physical, emotional, and spiritual damage caused by the chronic, progressive, and potentially fatal disease of addiction.

The average Patterns client enters treatment with two children and stays for 180 days after having been referred from a welfare, child welfare, public health, criminal justice, or mental health agency.

Treatment Services

Screening and assessment. Clients are screened with the Addiction Severity Index (ASI).

Outpatient services are available through other BHS programs, such as Family Recovery Centers in Boyle, Lincoln Heights, and South Bay.

Residential services. Clients stay in a dormitory-like house, with shared kitchen, laundry facilities, and child development center. Clients are introduced to 12-step programs, including Alcoholics Anonymous and Narcotics Anonymous, and receive individual and group counseling, HIV/AIDS education, and assertiveness training.

In-treatment support services include child care, transportation, clean and sober housing (both during and after treatment), exit planning, and parenting training.

Children are accepted from infancy to age 10 and receive a range of services, including a therapeutic play environment, opportunities for creative self-expression to identify their feelings, referrals to early intervention services, and access to local elementary schools.

Work and work preparation activities are required of clients as part of treatment and as a condition of graduating from treatment, with an emphasis on vocational rehabilitation counseling leading to self-support. Clients receive services both on- and off-site, including through links to literacy and GED preparation classes in the community. Patterns is currently working to refer clients to services through the Southern California Regional Occupational Center.

Work and work preparation activities are required of clients as part of treatment and as a condition of graduating from treatment, with an emphasis on vocational rehabilitation counseling leading to self-support.

Aftercare and support services are available in conjunction with outpatient programs affiliated with BHS.

Funding for Treatment

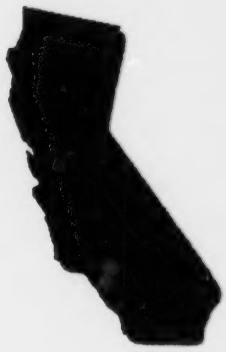
Three main sources support treatment services at Patterns – state and local appropriations (75 percent), TANF (15 percent), and client payments (10 percent). Patterns receives a small amount of funding also from food stamps and welfare-to-work funds through a local Private Industry Council.

Evaluation and Client Outcomes

Patterns began collecting process and outcome data in November 1998 to evaluate the success of clients and the program, including measuring work/vocational, employment, earnings, and welfare receipt outcomes. Aggregate data are not yet available.

Prototypes Women's Center
845 E. Arrow Highway
Pomona, California 91767
909-624-1233

Director: Carol Nottley



About Prototypes Women's Center

Founded in 1988, the Women's Center provides alcohol and drug treatment to women with children in residential, outpatient, and day treatment settings. The Center began by providing residential treatment, added outpatient services, and, most recently, implemented day treatment for recovering women and their children.

The Women's Center is part of a large multifaceted treatment organization under the Prototypes umbrella. The programs under the umbrella of Prototypes, a nonprofit organization, annually serve 10,000 women and their children who are homeless, battered, addicted to drugs or alcohol, and those living with or at risk for HIV/AIDS. Program sites are located throughout Southern California, with outreach teams also providing services in public housing developments as well as on the Street.

The goal of all of Prototypes programs, including the Women's Center, is to help at-risk women and their families recover and function in society by regaining control of their lives.

The goal of all of Prototypes programs, including the Women's Center, is to help at-risk women and their families recover and function in society by regaining control of their lives. The mission of the organization is the development and dissemination of innovative models of service delivery.

The average client enters Prototypes with three children and stays for 153 days after having been referred from a welfare, child welfare, public health, or criminal justice agency. Clients are ethnically diverse. Of the 702 clients enrolled between October 1992 and March 1997, 31 percent were white, 43 percent African-American, 24 percent Latina, 1 percent Native American, and 1 percent Asian/Pacific Islander. They ranged in age from 18 to 58 years old.

Many of the clients Prototypes served in 1997 were involved with public agencies. More than one-third (40 percent) had a child or children placed with Child Protective Services, and more than one-third (39 percent) were in treatment as a condition of parole or probation.

Clients entered treatment with a variety of problems in addition to their addiction. Nearly all (95 percent) had low literacy skills, more than half (52.5 percent) did not have a high school diploma or GED, nearly 14 percent had a co-occurring mental illness, and more than one-third (39 percent) had been a victim of domestic violence.

Treatment Services

Prototypes can accommodate more than 200 women and children in treatment at any given time – 178 or more in residential care, 50 in outpatient care, and 35 in day treatment. The average client waits 49 days for a treatment slot to open.

Screening and assessment. Clients are screened by trained clinical staff using a TMG Intake Questionnaire designed by Prototypes staff. The questionnaire explores clients' psychosocial history, takes a personality inventory, and relies on the Lufia-Nebraska addiction screening instrument.

Outpatient services, usually lasting from six to 12 months, include individual and group counseling, AIDS counseling and prevention, family therapy, parenting training, liaison with agencies (such as Department of Social Services), and referrals to community-based agencies providing other supportive services (such as housing, vocational training, and health care). Women can use the outpatient services to prepare for entering residential treatment, as their preferred type of treatment, or as continuing care after completing residential treatment. Priority is given to women who are at risk for HIV/AIDS or who are already HIV positive.

Residential services, usually lasting from six to 18 months, are designed to meet the special needs of pregnant and parenting women and are provided by interdisciplinary, culturally competent teams. Services include individual and group therapy, family therapy, 12-step meetings, parenting training, HIV/AIDS counseling, therapeutic recreation, and vocational and literacy training.

In-treatment support services include on-site child care and transportation services. Clean and sober housing is also available to treatment clients, as well as women who have completed treatment. Other support services include parenting training and planning for living outside of the treatment program.

When the women are ready (usually after about a month in treatment), they can choose among five training tracks – retailing, word processing, culinary arts, child care, or receptionist/office work.

Work and work preparation activities. Prototypes Women's Center has a multifaceted on-site work training program. When the women are ready (usually after about a month in treatment), they can choose among five training tracks – retailing, word processing, culinary arts, child care, or receptionist/office work. Each track lasts 12 weeks, with clients spending four hours a day/three days a week on the training activity. Clients are evaluated after six weeks of training and again after 12 weeks. Clients also accumulate work experience in their chosen training track by working in Prototypes' kitchen or thrift shop, for example.

After they have satisfactorily finished a module, they receive a certificate of completion, help with describing the experience on their resume, and a $50 certificate toward interview clothing. If they wish to continue their training, they can choose to repeat a module or receive training in one of the other four areas.

The Women's Center provides literacy training, and GED classes are held on site four days a week. Prototypes also provides a full complement of vocational readiness services, including job development. In 1998, Prototypes was one of nine programs selected nationally by the National Center on Addiction and Substance Abuse (CASA) to participate in a program to evaluate the effect of welfare-to-work policies on women with alcohol and drug problems.

Funding for Treatment

Public funding sources supporting services at Prototypes include: Substance Abuse Block Grant (28 percent), criminal/juvenile justice system (16 percent), categorical federal funding (11 percent – from the Center for Substance Abuse Treatment), TANF (10 percent), state and local appropriations (10 percent), Medicaid (6 percent), Ryan White CARE Act (6 percent), and food stamps (2 percent).

Prototypes also accepts private insurance, but less than 1 percent of its revenue is from that source.

Evaluation & Client Outcomes

For a 1998 evaluation, the Center studied outcomes for 124 women who had completed treatment within the last six months, with the average client staying in treatment for 239 days. The evaluation compares outcomes for the 47 women who had shorter stays in treatment (less than 180 days) and the 77 women who had longer stays in treatment (181 days or more).

The findings include:

- In the first three months after treatment, 37 percent of the women were working – 49 percent of women with longer stays in treatment, compared to 17 percent of women with shorter stays.
- In the last three months before the interview, 57 percent of the women were working – 63 percent of the women with longer stays, compared to 48 percent of the women with shorter stays.
- Women with shorter stays felt less able to meet their basic needs than women with longer stays.

Prototypes is also evaluating its computer training module. Since February 1998, it has followed up with 45 women who trained there and found:

- 80 percent have applied or interviewed for a job.
- 73.3 percent have worked in a job.
- 53.3 percent were working at the time of the follow-up interview.
- 33.3 percent had a job before leaving treatment.

Tarzana Treatment Centers
Women and Children's Residential Program
2010 Magnolia Avenue
Long Beach, California 90806
562-218-1868

Executive Director: Barbara McGrue

About Tarzana Treatment Centers

Tarzana Treatment Centers, founded in 1972, is a full-service behavioral health organization that specializes in providing high-quality, affordable treatment to adults and adolescents with alcohol, drug, and mental health problems. Located in Los Angeles, Tarzana offers a full continuum of services, including detoxification, residential treatment, day treatment, outpatient treatment, and sober living. The goal of services is to help clients develop the psychological, behavioral, and life skills necessary for building a satisfying alcohol- and drug-free lifestyle.

Clients at Tarzana follow a step-down approach to treatment. They participate in decreasing levels of treatment intensity as they make progress in their recovery.

Tarzana's Women and Children's Residential Program, located in Long Beach, is designed to meet the unique needs of women with children. Pregnant and parenting women are admitted with their children through referrals from a variety of public agencies, including welfare, child welfare, criminal and juvenile justice, public health, education, and mental health. The program also receives referrals from managed care organizations, private health care providers, and the clients themselves.

The average stay at the Women and Children's Residential Program is 180 days. Clients wait an average of three days for a treatment bed to open.

Treatment Services

Clients at Tarzana follow a step-down approach to treatment. They participate in decreasing levels of treatment intensity as they make progress in their recovery.

Screening and assessment. Each client is thoroughly assessed, with the results used to design a rapid, intensive treatment plan for crisis stabilization, short-term therapeutic intervention, specific recovery goals, and discharge planning for the next level of care.

Outpatient services are available in Long Beach to women who have graduated from the residential program. Outpatient treatment lasts 12 weeks, with clients attending a minimum of nine hours each week. Services are available during the day or at night, to accommodate clients' work schedules. After 12 weeks, clients can make a transition into aftercare if they need it.

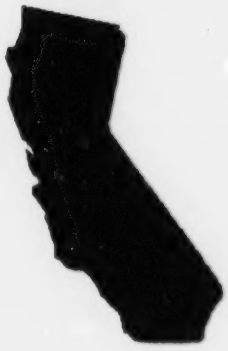
Residential services are provided in a therapeutic community designed to address all aspects of addiction, in a safe, supportive, and structured environment. Clients actively engage in a program of daily activities, including individual counseling, group process,

relapse prevention, education, family work, the 12 steps, recreation, creative expression, and other specialty group and individual services.

All clients participate in an on-site nursery cooperative, which provides child care and allows for experiential learning in parenting and child development. Women may bring up to two pre-school age children with them into treatment.

In-treatment support services include affordable child care, transportation, clean and sober housing during and after treatment, and exit planning.

Parenting training available at Tarzana is designed to satisfy the legal requirements for clients who are mandated to complete a parenting course. The class consists of 10 weekly, 90-minute sessions where participants learn about child development and specific techniques for effective parenting.



Work and work preparation activities are offered as part of the treatment program, and clients are required to engage in work activities to graduate. Currently, training occurs off-site, although occupational and vocational therapists are available to clients on-site. Clients are also linked with literacy and GED training programs in the community.

Tarzana staff are working to secure funding to have training available at the Long Beach facility. They are also working to build relationships with local employers to increase employment and job training opportunities for clients.

Tarzana staff are working to secure funding to have training available at the Long Beach facility. They are also working to build relationships with local employers to increase employment and job training opportunities for clients.

Aftercare and supportive services consist of weekly group meetings and semimonthly alumni meetings for clients who have completed their residential and outpatient program. Meetings address day-to-day and long-term challenges to recovery.

Sober housing specifically for women and children is available for treatment graduates who believe they could benefit from the support of living with other people in recovery as they transition into independent living in the community. Sober living apartments are available near the Long Beach facility, allowing convenient access to outpatient care. Each house has an on-site, live-in manager who is responsible for the supervision of their adherence to house rules.

Funding for Treatment

Four sources of funding support treatment services at Tarzana's women's program – the Substance Abuse Block Grant (50 percent), TANF (40 percent), the Ryan White CARE Act (5 percent), and client payments (5 percent).

Evaluation & Client Outcomes

Client success is evaluated using outcome measures, including the work-related measures of changes in client employment and receipt of welfare. No aggregated data, however, are currently available. Tarzana is in the process of developing and implementing a program evaluation.

FLORIDA

PAR Village
10901C Roosevelt Boulevard, Suite 100
St. Petersburg, Florida 33716
727-545-7564

President: Shirley Coletti
Chief Executive Officer: John Young
Program Director: Jonathon Lofgren

PAR's mission is to provide high quality, research-based behavioral health care services for those affected by alcohol, drug, and mental health problems.

About PAR

PAR Village is a long-term residential program for women with alcohol and drug problems and their children. The program helps women rebuild their families while they rebuild their lives by allowing them to have custody of their children while in treatment.

PAR Village's parent agency, PAR (which stands for Parental Awareness and Responsibility) has delivered comprehensive behavioral health care services to families in West Central Florida since 1970. PAR's mission is to provide high quality, research-based behavioral health care services for those affected by alcohol, drug, and mental health problems. It provides a full continuum of care for individuals with alcohol and drug problems, including non-hospital residential, outpatient, day treatment, detoxification, and methadone maintenance services.

About one-quarter (28 percent) of PAR Village's clients are required to be in treatment as a condition of parole or probation. About one-quarter (29 percent) have not graduated from high school or have a GED. About one-quarter (27 percent) also have a mental illness in addition to an alcohol or drug problem. Clients arrive at PAR Village through referrals from a variety of public sources, including the welfare, child welfare, criminal justice, public health, education, and mental health systems.

Treatment Services

PAR Village can accommodate 57 women and 33 children at any given time. Women are permitted to bring two children under the age of 10 with them into treatment. The average client spends 107 days in treatment, after waiting five days for a treatment slot to open

Screening and assessment. Women are assessed using an instrument developed at the program.

Outpatient services, including relapse prevention, are available to PAR Village clients who have finished residential treatment through other PAR programs, which can accommodate more than 1,000.

Residential services include individual and group counseling, support groups, life skills training, medical services, and domestic violence groups. Psychiatric evaluation and fol-

low-up appointments are also available for women who have mental health problems in addition to their alcohol and drug problems.

In-treatment support services include child care, transportation, parenting training, and exit planning. Clients have clean and sober housing available during treatment and are referred to other housing resources in the community when they complete treatment.

Children between birth and five years old attend the PAR Village Developmental Center, a licensed, therapeutic preschool providing developmental testing and assessment, speech, physical and occupational therapies and community referrals. Teachers at the center work with mothers to demonstrate bonding techniques and enhance family relationships.

Work & work preparation activities. For clients who are eligible for Florida's welfare program, WAGES, a welfare caseworker works with PAR Village's vocational program director to coordinate a client's work readiness activities and work requirements. PAR Village clients are initially exempted from work requirements so that they can focus fully on treatment and recovery. Clients also go to school, if necessary, to become ready to work.

When they arrive at the program, clients are assessed to determine their vocational skills, including educational skills, work history, and work gaps. PAR's goal is for all clients to get at least a 9th grade education or their GED. If a client has less than a 9th grade education, she must go to the public school with which PAR is affiliated.

After focusing on treatment for three to four months, clients participate in a work-readiness vocational group for eight weeks. Group activities include preparing a resume and improving communication skills in preparation for interviews. Clients then start the process of finding appropriate jobs that will help them prepare and engage in a career.

Aftercare and support services available include case management and continuing care therapy groups after discharge from residential treatment.

After focusing on treatment for three to four months, clients participate in a work-readiness vocational group for eight weeks.

Funding for Treatment

Services at PAR Village are supported by multiple sources, including client payments (12 percent), Medicaid (5 percent), the Substance Abuse Block Grant (3 percent), criminal/juvenile justice agencies (3 percent), Ryan White CARE Act (2 percent), TANF (1 percent), food stamps (1 percent), state and local appropriations (1 percent), and private health insurance (1 percent).

In 1992, PAR Village received a five-year CSAT grant, which expired last year. The program has made up part of that loss through a $500,000 grant from the Florida State legislature.

Evaluation and Client Outcomes

PAR Village collects both process and outcome data to evaluate program success. Outcome measures examined include employment status and receipt of public assistance.

PAR Village's client outcomes demonstrate the effectiveness of the program. Key findings include:

- Nearly two-thirds (64.7 percent) of clients are drug-free and almost all (88 percent) are arrest-free six months after completing treatment.
- Almost all clients (95 percent) attain the education and/or vocational skills necessary for employment, and more than one-third (35 percent) are employed six months after completing treatment.
- Nearly three-quarters (72.5 percent) attain custody of their children within six months after completing treatment.

The Village
3180 Biscayne Boulevard
Miami, Florida 33137
305-575-3784

Executive Director: Matthew Gissen

About The Village

The Village, founded in 1973, is a nonprofit agency that provides alcohol and drug treatment to the South Florida community. Its programs offer a range of services, including rehabilitation and counseling in individual and group therapy sessions, vocational and basic education, outreach, and intervention and prevention for clients' families. Services are provided in a comprehensive, holistic, and multidisciplinary way by a culturally competent and professional staff.

The Families in Transition (FIT) program, part of the Village, provides comprehensive residential alcohol and drug prevention and treatment services for women and their children. FIT creates a therapeutic environment where mothers and children can live together and rebuild their lives by experiencing physical, emotional, spiritual, educational, vocational, and social recovery that will enable them to live successfully when they return to the community.

FIT creates a therapeutic environment where mothers and children can live together and rebuild their lives by experiencing physical, emotional, spiritual, educational, vocational, and social recovery that will enable them to live successfully when they return to the community.

Clients enter the Village through referrals from a variety of sources, including the child welfare, criminal and juvenile justice, public health, and mental health systems. Clients also self-refer to the Village.

Women who enter treatment at the Village face a range of problems and challenges other than their addiction to alcohol and drugs. Most have been victims of domestic violence (85 percent). Many are chronically underemployed (85 percent), have low literacy skills (25 percent), and have not graduated from high school or obtained their GED (60 percent). Many are affected by other illnesses, such as HIV (25 percent) and mental illness (40 percent), including depression and post-traumatic stress disorder. Many of the women are also involved in the criminal justice system (15 percent) or child welfare system (70 percent). In addition, the children require specialized assessment, coupled with developmental and remedial services, which are provided in collaboration with the University of Miami.

Treatment Services

The Village can accommodate 60 women in treatment at a time in 20 residential slots, 20 outpatient slots, and 20 day treatment slots. The average client enters treatment with two children after waiting 45 days for a bed to open. Families live together while the women progress through treatment, which lasts an average of seven months.

Screening and assessment. Clients are screened and assessed by trained staff who administer several assessment tools, including the Addiction Severity Index (ASI),

Substance Abuse Subtle Screening Inventory (SASSI), Perinatal Stress Index, and Beck Depression Inventory.

Outpatient services, such as individual and group counseling, are available to clients after they have completed the residential portion of their treatment. These services are available during evening hours to accommodate work schedules.

Residential services include individual, group, and family therapy. Clients also attend daily AA/NA meetings and receive training and education about health, child development, addiction, parenting, relationships, and relapse.

Most clients need help preparing for work, and the Village engages them in several activities that help them achieve and sustain employment. These activities include basic skills, such as resume writing, basic computer skills, and personal presentation skills.

In-treatment support services include child care, transportation, clean and sober housing, parenting training, and exit planning. The women also receive psychological and psychiatric services, which are integrated into the client's individualized treatment plan. In addition, throughout a client's stay, the Village maintains contact with the referring agency.

Children at the Village receive individualized services, including newborn services at local hospitals, developmental screening, specialized day care and developmental services, and prevention programs for drug- and alcohol-exposed infants and children. If children are school-age, they attend local schools while they live at the Village.

Work and work preparation activities. A principal goal of the Village is to reduce family reliance on public assistance. If clients have not completed their high school education, they attend classes that prepare them for their GED. All graduates from the Village leave with their GED.

In addition to educational assessment and improvement, the Village tests clients for work readiness when they enter treatment and before they leave. Most clients need help preparing for work, and the Village engages them in several activities that help them achieve and sustain employment. These activities include basic skills, such as resume writing, basic computer skills, and personal presentation skills. The Village also sends clients to off-site vocational education programs that teach job skills, including more advanced computer skills, clerical skills, and industry skills.

Before clients graduate from the Village, they engage in the process of finding a job and working. Clients are encouraged to find jobs where they work during the day and that do not include relapse triggers, such as discretionary funds (tips), high stress, and shifts at night. Clients attempt to find jobs in the areas in which they will live and their children will attend schools and that are accessible through their available transportation.

Aftercare and support services. After discharge, the Village continues to maintain relationships with its clients. The staff helps clients and their children adjust to life in the community by offering regularly scheduled counseling and a Co-op "Help" Center, where mothers can volunteer their time in return for child care while they are at work. Clients also are encouraged to prevent relapse and maintain long-term recovery by continuing to attend AA/NA meetings.

Funding for Treatment

The Village receives funding to support its services from four sources – state and local appropriations (88 percent), Medicaid (5 percent), TANF (5 percent), and food stamps (2 percent).

Evaluation & Client Outcomes

Recent evaluations of the FIT program have found that most clients remain abstinent from alcohol and drugs, find employment, and do not rely on welfare assistance. At one year after discharge:

- 87 percent of graduates were drug-free, and 93 percent had attained needed education or vocational skills for employment.
- 58.1 percent were employed or in vocational training, compared to 5.8 percent at admission.
- 33 percent were completely independent from welfare and 56 percent were dependent on some welfare, compared to 100 percent who were completely dependent on welfare at admission.

Almost all of the former clients who were not working (91.3 percent) reported facing specific barriers to finding a job, including lack of child care (26.3 percent), participation in another treatment program or incarceration (25 percent), lack of jobs available (20 percent), other commitments and responsibilities (11.3 percent), and a lack of job skills and tools (11.3 percent).

The FIT program also produced good child welfare system results by unifying families. Of the children served by the program at the time of the evaluation, 95 percent were reunified with their mothers, generating nearly $2 million in savings to the foster care system.

ILLINOIS

Haymarket Center
Athey Hall
120 North Sangamon Street
Chicago, Illinois 60607
312-226-7984

Program Director: Raymond F. Soucek

Haymarket Center provides a full continuum of treatment services to women, men, and families affected by alcoholism and drug dependence, including the homeless and court-mandated offenders throughout the Chicago metropolitan area.

About Haymarket Center

Haymarket Center provides a full continuum of treatment services to women, men, and families affected by alcoholism and drug dependence, including the homeless and court-mandated offenders throughout the Chicago metropolitan area. The primary goal of treatment at Haymarket Center is independent living in recovery.

Women clients with children enter Haymarket Center facing a variety of challenges to recovery and independence, being referred by the welfare, child welfare, criminal justice, public health, and mental health system. Nearly 70 percent are involved with the child welfare system, 85 percent have a history of relapse, 70 percent are chronically unemployed and do not have a high school diploma or GED, and 30 percent have a co-occurring mental illness.

Treatment Services for Women

Haymarket provides many services specifically for women, including programs for pregnant and post-partum women and women with children. Specialty women's services include:

- Athey Hall, a 25-bed, long-term (10 to 12 months) primary residential treatment program for women with children (from birth to 4½ years old), which serves many welfare families.
- Women's Residential Treatment Program, which can accommodate 16 women in treatment without their children.
- Maternal Addiction Program, which includes two 16-bed primary treatment programs for pregnant addicted women 18 years and older who may be admitted any time during their pregnancy and who may stay until they deliver.

Screening and assessment. Assessment is conducted by Haymarket Center's Central Intake Assessment Department, using the Addiction Severity Index (ASI) and examining the client's family, social, financial, medical and psychiatric history, and current physical health status. Patient placement decisions are based on ASAM criteria.

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Linkage with a local chapter of Catholic Charities helps clients receive education and vocational training.

Outpatient services are available to as many clients as need them, including gender-specific outpatient groups and activities. Haymarket has multiple outpatient programs for women. These serve parenting women, including pregnant and postpartum women, many of whom are involved with the child welfare system. Outreach workers pick up the women and their children each day, take them to treatment, and return them home at the end of the treatment day. The women attend outpatient treatment, while the children attend Haymarket's licensed day care.

Residential services for women on welfare are provided in family units. Clients stay in residential care at Haymarket Center for an average of 28 days, after waiting 10 days for a treatment slot to become available. Services available during the residential portion of treatment include individual and group counseling, sober lifestyle activities, family counseling and education, and case coordination. Gender-specific services are available for women, including counseling, support meetings, and continuing care groups that are women-only and address spirituality, gender issues, and domestic violence issues.

In addition, Haymarket/Maryville has three 16-bed residential treatment programs for postpartum women. Two of the programs are primary treatment and allow women to work on recovery skills while bonding with their infant, as well as work with the courts to gain or regain custody of an infant who tested positive for drugs at birth. The third program allows women to have newborns and toddlers in residence, integrating parenting and recovery.

In-treatment support services include child care, transportation, exit planning, parenting training, and medical care. Children receive a range of services, including a summer prevention program. Other services include psychiatric assessment, consultation, and evaluation, drug screening, emergency medical services, and linkages to specific services in the community.

Work and work preparation activities begin for clients in the third phase of treatment, after about six months, and occur off-site. Linkage with a local chapter of Catholic Charities helps clients receive education and vocational training. Clients are also referred off-site to community-based literacy and GED training programs.

Aftercare and support services. An on-site women's recovery home can house up to 25 women and their children for six to 12 months, while they receive services to help them maintain their recovery. During their stay in the recovery home, the women and their families participate in outpatient or aftercare treatment programs, attend school or prepare for employment, arrange day care or baby sitting for their children living with them, and learn to maintain an alcohol- and drug-free lifestyle. Other available services include case management and referral, relapse prevention, and continued parenting education. Clean and sober family housing is also available off-site to clients after they have completed treatment.

Funding for Treatment

Services at Athey Hall are funded entirely through a CSAT grant through the Residential Women with Children program.

Evaluation & Client Outcomes

Haymarket Center collects both process and outcome measures – including vocational, employment, and public assistance receipt data – to evaluate the success of its clients.

An evaluation of nearly 200 clients treated between April 1996 and July 1998 found that:

- More than half (56.3 percent) were working one year after completing treatment. Nearly all of the women treated at Athey Hall are unemployed at the time they are admitted. (A subgroup of 28 clients who completed treatment between September 1997 and July 1998 found jobs paying an average of $7.10 per hour – ranging from $5.75 to $16 per hour.)
- Involvement with the child welfare system fell from 4.2 percent at one month after discharge to 0 percent involved two years after completing treatment.
- Three-quarters were not using alcohol and more than 85 percent were not using drugs one year after completing treatment.

A subgroup of 28 clients who completed treatment between September 1997 and July 1998 found jobs paying an average of $7.10 per hour – ranging from $5.75 to $16 per hour.

Rosecrance Health Network
Project Next Step
420 West State Street
Rockford, Illinois 61104
815-967-8722

Project Director: Mimi Bazuin

Rosecrance's Project Next Step focuses specifically on women receiving welfare.

About Rosecrance and Project Next Step

Rosecrance Health Network is a multifaceted nonprofit agency committed to delivering high-quality behavioral health-care services to men, women, children, and families. Rosecrance has provided these services in Rockford since 1916.

Rosecrance's alcohol and drug treatment programs are based on the disease model of addiction and integrate individual client differences and emphasizing a 12-step approach. Services are provided by a multidisciplinary treatment team that includes a board-certified addictionologist and medical director, an attending physician, licensed clinical social workers, certified substance abuse counselors, professional nursing staff, a chaplain, and a consulting dietician.

Rosecrance's Project Next Step focuses specifically on women receiving welfare. In addition to receiving welfare, clients at Project Next Step are women 18 and older who are experiencing the addictive use of drugs and alcohol, including significant deterioration in life areas (such as family, social, personal, financial, and legal). While receiving treatment for their addiction, clients are encouraged to overcome barriers to employment, including the difficulty of arranging for affordable transportation and child care.

Project Next Step's treatment services are part of a three-site pilot (the other sites are Chicago and Peoria) in Illinois that began in early 1997 to require welfare recipients with alcohol and drug problems to be in treatment to receive benefits. Rosecrance received $1 million in FY 97 to participate. As part of the project, Rosecrance staff trained caseworkers at the local office of the state Department of Human Services to recognize signs of addiction among clients and refer those clients to Rosecrance for clinical assessment. Rosecrance's previous work with families involved in the child welfare system as a result of parental alcohol and drug problems meant that Rosecrance staff already had developed good working relationships with the local office of the state human services agency before the 1996 federal welfare law was enacted.

Treatment Services

Project Next Step provides women on welfare with an array of individualized services. Women stay an average of 62 days in residential treatment. Women bring an average of three children to Project Next Step with them. Detoxification services are available on-site in a medically monitored environment to help clients withdraw safely from alcohol and drugs.

Screening and assessment. Women receive in-depth assessment using Project Next Step's own assessment tool, as well as a family assessment tool developed with the

Rosecrance bought and opened a shrink wrapping plant, where clients can gain work and work training experience.

Illinois Department of Human Services. Decisions about the level of care needed are based on ASAM criteria and a thorough review of a client's profile.

Outpatient services are available for as many clients as need them. These services include ongoing assessment, group and individual counseling, and a partial hospitalization program that allows clients to participate in intensive services five days per week.

Residential services at Rosecrance can accommodate 16 women, 16 men, and four families. Women on welfare can stay in the family unit during the residential portion of their treatment or in the women's inpatient unit.

Services available during the residential phase of treatment include individual and group counseling, sober lifestyle activities, family counseling and education, spirituality, relapse prevention, 12-step opportunities, and case coordination. Gender-specific services are available for women, including counseling, support meetings, and continuing care groups that address spirituality, gender issues, and domestic violence issues.

In-treatment support services include child care, transportation, discharge planning, and parenting training. Children receive a range of services, including a summer prevention program. Other services include psychiatric assessment, consultation, and evaluation, drug screening, emergency medical services, and linkages to specific services in the community.

Work and work preparation activities occur both on- and off-site, including work experience clients can gain by performing tasks at the treatment program. In mid-1998, Rosecrance bought and opened a shrink wrapping plant, where clients can gain work and work training experience.

Training programs at the local Goodwill Industries are also available to clients. In addition, Project Next Step provides linkages to literacy and GED programs in the community. Clients can also work toward their education at recently created on-site GED program, which meets on Tuesdays and Thursdays.

Continuing care and support services. Rosecrance maintains an active group of recovering adults in an alumni club that provides opportunities for social, recreational, and other activities. Rosecrance operates Employee Assistance Programs (EAPs) for local employers.

Transitional housing that is clean and sober is also available for women with children. The housing is within walking distance of the main treatment facility, making continuing care accessible for clients who are working to maintain their recovery and enter the work force simultaneously.

Funding for Treatment

Funding for treatment services come from three main sources. Medicaid makes up about one-quarter of the program's funding (25 percent), with private health insurance constituting about 15 percent. The other 60 percent comes from the Illinois Department of Human Services Office of Alcohol and Substance Abuse, which includes a combination of funding from the federal Substance Abuse Block Grant, TANF, and state appropriations.

Evaluation & Client Outcomes

Rosecrance collects both process and outcome measures, including vocational and employment data, to evaluate the success of its programs.

Through the first months of 1998, 392 TANF recipients were engaged in Project Next Step. Of these, 292 (74.5 percent) were referred by the local Department of Human Services office and 134 (34.2 percent) are currently enrolled in treatment. Some of the outcomes for these clients include:

- 66 obtained employment.
- Six obtained a GED certificate.
- Five enrolled in college full-time.
- 12 enrolled in on-the-job training or apprenticeship programs.
- Eight drug-free infants were born to participants.

The Women's Treatment Center
140 North Ashland
Chicago, Illinois 60607
312-850-0050

Executive Director: Jewell Oates

About The Women's Treatment Center

The Women's Treatment Center (TWTC) opened in 1990 to provide alcohol and drug treatment to women with children on the site of the former Mary Thompson Hospital. The hospital opened in 1928 to provide work for women physicians and medical services for women and children.

TWTC considers itself a "one-stop shop," with a campus that provides a variety of services to women in one location and erases barriers to treatment for women.

TWTC's mission is to provide comprehensive, compassionate, and clinically appropriate alcohol and drug treatment services for women and their children. The goals of the program are to promote healthy living through recovery from dependence on alcohol and drugs, improve parenting and family skills, and reduce infant morbidity (including HIV infection) and mortality associated with perinatal addiction.

TWTC considers itself a "one-stop shop," with a campus that provides a variety of services to women in one location and erases barriers to treatment for women. Women enter treatment with between one and seven children, after having been referred from a welfare, child welfare, public health, or criminal justice agency. Women wait an average of two to three weeks for a treatment slot to become available for them and their children.

Most TWTC clients enter treatment with few job skills. Nearly all (90 percent) do not have a high school diploma or GED, and half (50 percent) have low literacy skills. All clients have a history of chronic unemployment.

Treatment Services

The program can accommodate a total of 48 women in residential treatment. At any given time, more than 50 children are living in the program with their mothers. Services are available for up to two years.

Screening and assessment. Women receive a clinical assessment when they enter the program, with placement decisions based on ASAM criteria.

Outpatient services. Intensive and regular outpatient programming are available for women who have completed residential treatment or whose needs are less intensive. Women may bring their children to the on-site daycare program while they attend their outpatient sessions. Specialized outpatient services are available for 12 months to women with children less than five months old and who are involved with the child welfare system.

Residential services are available in several durations and intensities. The Long-Term Residential Rehabilitation Program offers one to three months of parenting, alcohol and

drug treatment, and daily life skills for women and their children. The Pregnant and Postpartum Women with Infants Program, designed for women in their seventh month of pregnancy or later or mothers with newborns less than one month old, provides transitional services to support them during this high-risk relapse period. Two other residential programs, City Girls and City Women, are run by Interventions, a TWTC partner in the community.

In-treatment support services include transportation, clean and sober housing, exit planning, and parenting training. Medical and social services, such as prenatal care, pediatric care, and HIV testing and counseling are available on-site or through cooperative agreements with other local community-based organizations. AA and NA meetings are also available on-site.

Fully licensed day care is available for 20 infants and 25 toddlers. Other children's services include a special pre-kindergarten program staffed by the Chicago Board of Education that can accommodate 16 children and a crisis nursery that provides 24-hour care to children whose mothers are in crisis. Assessment and early intervention for children 0-3 are also available.

Work and work preparation activities are expected from women who are graduating from outpatient treatment. Residents of the group recovery home are expected to find employment or enter a school program to obtain a GED or a higher degree, if desired. TWTC staff also help residents enroll in off-site job training and placement programs.

In mid-1998, TWTC received TANF funding from the state to provide job readiness training to treatment clients. TWTC program staff have been working with the staff at the local Department of Human Services office to implement the program.

Aftercare and support services include a group recovery home for women who have completed residential services who require a safe, drug-free environment in which to build a new life. The recovery home, where women can stay from three to 18 months, can accommodate single women and women with children from infancy to five years old. Residents are required to attend outpatient treatment.

Clients can also later move to Madison House, an off-site transitional living facility with security for women with children who have completed treatment and are working to live in recovery.

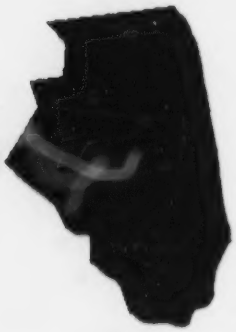
In mid-1998, TWTC received TANF funding from the state to provide job readiness training to treatment clients. TWTC program staff have been working with the staff at the local Department of Human Services office to implement the program.

Funding for Treatment

Four main sources support treatment services at TWTC – Medicaid (75 percent), federal categorical funding from CSAT (10 percent), private health insurance (10 percent), and the Ryan White CARE Act (5 percent).

Evaluation & Client Outcomes

TWTC collects both process and outcome measures, through a survey of clients, to evaluate program effects but lacks the resources to aggregate and analyze the data.



White Oaks New Leaf for Women
Human Service Center
3500 New Leaf Lane
Peoria, Illinois 61614
309-692-6900

Executive Director: Lillie M. Bennett

About New Leaf for Women

About three-quarters (76 percent) of New Leaf's clients have had a child or children placed with child protective services. The same number (76 percent) are chronically unemployed.

New Leaf for Women is an alcohol and drug treatment program serving women with children. It is part of Human Service Center (HSC), a multifaceted addiction treatment program offering a comprehensive continuum of services to the Peoria community.

The program strives to provide services in a setting that is gender-specific and culturally relevant to clients. Part of New Leaf's treatment mission is to help women build support systems to empower and enhance their ability to change, as well as their willingness to hope.

Clients arrive at New Leaf via referrals from a welfare, child welfare, public health, or criminal justice agency. New Leaf also does outreach to local Head Start, community, and housing agencies.

About three-quarters (76 percent) of New Leaf's clients have had a child or children placed with child protective services. The same number (76 percent) are chronically unemployed. A little more than half (55 percent) do not have a high school diploma or a GED.

Treatment Services

New Leaf can accommodate 32 women and children at one time in residential treatment, 15 women in outpatient care, and 12 women in aftercare. Clients stay in residential treatment for an average of 56 days, and most do not have to wait for a treatment slot to open.

Screening and assessment. Clients are screened using the Addiction Severity Index (ASI) at an HSC central intake facility.

Outpatient services are available on-site, as well as through other HSC programs, such as Amethyst Clinic, which provides outpatient services during both day and evening hours. Women are also encouraged to participate in AA/NA groups in the community.

Residential services include group, individual, and family counseling. Services focus on supporting women as they adjust to recovery, pregnancy, and new motherhood. Medically managed detoxification is also available in an on-site 10-bed unit.

In-treatment support services include parenting training, clean and sober housing, and exit planning. Pre- and post-natal care for mothers and their infants is also available through agreements with local clinics and health care providers.

Parenting training emphasizes women's roles and identities as new mothers in early recovery. Day care is available for children when their mothers are in group therapy, but the women are responsible for them at other times.

Transportation assistance is also available to clients from Peoria who are participating in Project Safe, a program that targets alcohol and drug treatment services to families involved in the child welfare system.

Work and work preparation activities are not required as part of treatment, but referrals are available for women to work training programs in the community. Clients are referred to the local Urban League for job training and to other community-based organizations for GED and literacy programs.

Some of the women who enter treatment at New Leaf are already working, while others begin job preparation late in treatment or after treatment. The closer a client is to finishing treatment and beginning aftercare, the more she is likely to engage in work and work training.

The closer a client is to finishing treatment and beginning aftercare, the more she is likely to engage in work and work training.

Aftercare and support services include a four-bed apartment that is available to women making the transition out of the treatment program and back into the community.

Funding for Treatment

Information on sources of funding for services at New Leaf was not available.

Evaluation & Client Outcomes

Evaluation of the outcomes of 98 clients who participated in New Leaf's CSAT-funded program for Pregnant and Postpartum Women found that:

- The number receiving job income in the previous 30 days increased by almost 500 percent – from 7.6 percent at intake to 36.7 percent at follow-up.
- The number who were homeless dropped by half – from 24.7 percent at intake to 12.2 percent at follow-up.
- The number who had used their primary drug of abuse in the last 30 days decreased by nearly 300 percent – from 76.5 percent at intake to 25.9 percent at follow-up.
- The number who had used alcohol dropped by nearly 200 percent – from 51 percent at intake to 27.6 percent at follow-up.

At six-month follow-up of 100 treatment clients:

- 30 (30 percent) were employed all of the previous 30 days.
- 4 (4 percent) were in training.
- 30 (30 percent) were unemployed and not looking for work.
- 21 (21 percent) were unemployed and looking for work.

- 6 (6 percent) were employed in the last month but for less than 30 days.
- 3 (3 percent) were disabled.

Evaluation of employment outcomes for 53 Peoria County TANF clients who were admitted to treatment between October 1, 1996, and March 27, 1998, found that:

- 17 (32 percent) were discharged when treatment was complete. Of those, 10 (59 percent) were employed.
- 26 (49 percent) were discharged from treatment before they had completed it. Of those, eight (30.7 percent) were employed.
- 10 (19 percent) were still in treatment at the time of the evaluation. Of those, three (30 percent) were employed.

MAINE

Crossroads for Women
114 Main Street
Windham, Maine 04062
207-892-2192

Executive Director: Kim Johnson

About Crossroads for Women

Crossroads is the only all-women's alcohol and drug treatment facility in Maine and has provided residential and outpatient treatment to women and women with children for more than 20 years. The philosophy at Crossroads, a private nonprofit organization, is to take a holistic approach to alcohol and drug treatment – designed to enrich the mind, body, and spirit and help women understand their addiction and recovery.

Clients are women 16 and older who have alcohol and drug problems. Children under 10 may accompany their mothers in residential treatment, and the average woman in treatment at Crossroads has two children. Clients enter through a variety of referral sources, including welfare and child welfare agencies.

Treatment Services

Crossroads can accommodate 104 women at a time in treatment – 14 in residential care, 75 in outpatient care, and 15 in day treatment. The average client waits 10 to 14 days for a treatment slot to open.

Screening and assessment. Clients are screened by trained clinical staff using a psychosocial assessment tool. Decisions about treatment placement are made based on the assessment, as well as reports from other treatment providers who have worked with the client, reports from the referring agency, physician and psychiatric records, and the findings of a treatment team evaluation.

Outpatient services include individual, group, and family counseling.

Residential services are designed to help clients identify and accept their addiction and develop appropriate coping skills for staying alcohol- and drug-free. The program requires participation in individual counseling, group counseling, and self-help programs, such as AA and NA. Topics that affect recovery are addressed during treatment, including domestic violence and parenting. Length of stay varies from between 14 and 60 days.

In-treatment support services include on-site child care and program staff available to work with local schools to ensure continuing education and a smooth transition back into the community for the children of clients.

An empowerment group helps women discuss their post-treatment responsibilities, including work. A volunteer career counselor also is available every two weeks to work with the women to assess their job skills, aspirations, and outlook.

Work and work preparation activities. Crossroads clients are referred off-site for work and work preparation activities, which happen concurrently with clinical services. Crossroads also provides linkages to literacy and GED programs in the community.

The duration of the short-term residential program limits work and work preparation opportunities during treatment, but an empowerment group helps women discuss their post-treatment responsibilities, including work. A volunteer career counselor also is available every two weeks to work with the women to assess their job skills, aspirations, and outlook. Work and education plans are also part of clients' aftercare planning.

Aftercare and support services help stabilize a client and prevent relapse by identifying relapse symptoms and strategies for maintaining sobriety.

Funding for Treatment

Crossroads accepts clients regardless of their ability to pay. Public funding sources supporting services at Crossroads are: Medicaid (40 percent), Substance Abuse Block Grant (30 percent), state and local appropriations (10 percent), and food stamps (5 percent).

Crossroads also accepts private insurance (10 percent of its current revenue) and provides a sliding scale payment plan for clients who pay out-of-pocket (5 percent).

Evaluation & Client Outcomes

Between 1995 and 1998, Crossroads staff were able to locate nearly half of their clients within 30 days after treatment. Of those, nearly three-quarters (73 percent) reported that they were alcohol- and drug-free, and one-quarter (25 percent) reported that they were working or in school.

At six-months follow-up, Crossroads staff were able to locate one-third of their clients. Of those, more than half (56 percent) remained alcohol- and drug-free and one-quarter (25 percent) were working.

At one-year, Crossroads staff were still able to locate one-quarter of their clients (26 percent). Of those, more than half were still abstinent (57 percent) and more than one-third (43 percent) were working or in school.

MARYLAND

Avery House
Halfway House for Women and Children
14705 Avery Road
Rockville, Maryland 20853
301-762-4651

Executive Director: Elaine Reed

About Avery House

Avery House is a five-year-old halfway house designed to meet the needs of recovering women and their children in a structured, supported, and sober environment. Women enter Avery House after completing a primary alcohol and drug treatment program somewhere else in the county.

Programming emphasizes trust, integrity, self-discipline, and self-discovery to help women move toward personal and economic independence and to care for their children. Avery House strives to foster recovery through a home community that allows individual women to effect personal change to improve the quality of their lives and the lives of their children.

Most clients enter Avery House with a limited work history. About 60 percent have worked "odd" jobs, while about 40 percent have not worked at all. Nearly 20 percent have low literacy skills, and only 15 percent have their GED or a high school diploma. Nearly two-thirds (60 percent) have a criminal justice history, with 10 percent in treatment as a condition of parole or probation.

Most clients enter Avery House with a limited work history. About 60 percent have worked "odd" jobs, while about 40 percent have not worked at all.

Treatment Services

Avery House can accommodate a total of 20 women and children at one time. Usually, 10 women and 10 children live there together. The average client stays for 250 days.

Residential treatment services include individual, group, and family counseling, parenting and child development classes, addiction education, health and nutrition groups, smoking cessation, nursing and prenatal care, therapeutic recreation and socialization, and life skills groups. Twelve-step groups, like AA and NA, are also available on-site.

In-treatment support services include transportation, child care, clean and sober housing, exit planning, and parenting training. Infant and child care is available from 7:30 a.m. to 6 p.m., while mothers are at work, school, or group therapy.

A children's counseling program includes creative play and activities to introduce children to positive peer interaction and give them a nurturing and supportive environment with positive adult role models. Parenting training focuses on positive parenting techniques, maternal and child bonding, non-punitive child-rearing practices, anger management, and issues concerning single parenting.

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Work and work preparation activities. Avery House residents are required to work full or part time or attend school or work training within the first 30 days of arriving, as well as to graduate from the program. Clients are expected to return home by 6 p.m. during the week, and all treatment activities are planned for the evening to accommodate work and school schedules. Clients are not permitted to quit their job until they find another.

Avery House staff help clients develop work skills. Key activities include resume writing, acquiring appropriate work attire, and learning telephone skills. Clients are referred to vocational training, GED, and literacy programs in the community.

Avery House staff are also available to facilitate communication between clients and their employers and clients and their welfare and child welfare case workers.

Avery House staff are also available to facilitate communication between clients and their employers and clients and their welfare and child welfare case workers.

Aftercare and support services, such as assistance in finding housing in the community, are available. Program staff also help clients plan for meeting their child care and transportation needs after they leave the program.

Funding for Treatment

Avery House's services are funded entirely through the Substance Abuse Block Grant.

Evaluation & Client Outcomes

As of April 1998, Avery House had served 70 women and 66 children, with the first resident graduating in June 1995. Outcomes for the program include:

- 85 to 90 percent of clients begin full- or part-time work or school within the first 30 days of arriving at the program, including as dental assistants and receptionists.
- 24 children have been reunified with their mothers while in the program.
- 70 of the women have gained employment while at the program, eight have enrolled in GED classes, and three have entered college.
- successful coordination with the local health department, social services agency, foster care parents, courts, and more than 35 private community programs.
- establishment of on-site health and prenatal care and coordination with outside providers.

Center for Addiction and Pregnancy
4940 Eastern Avenue
Baltimore, Maryland 21224
410-550-3033

Executive Director: Dace Svikis

About the Center for Addiction and Pregnancy

The Center for Addiction and Pregnancy (CAP) was created in 1991 to provide alcohol and drug treatment services to pregnant and post-partum women and their children. CAP addresses the needs of women with alcohol and drug problems in a multidisciplinary, "one-stop shopping" approach housed entirely in one wing of the Johns Hopkins Bayview Medical Center.

CAP addresses the needs of women with alcohol and drug problems in a multidisciplinary, "one-stop shopping" approach housed entirely in one wing of the Johns Hopkins Bayview Medical Center.

CAP's goals are to: (1) reduce the number of obstetric complications, including HIV infection, (2) improve birth outcomes while reducing alcohol and drug use, (3) provide effective family planning services that are acceptable to the client, and (4) ensure initial and long-term pediatric assessment and care of clients' children.

Clients are predominantly African-American, unemployed, single women on public assistance. They are pregnant when they enter the program and have an average of two children. They spend 60 to 90 days in treatment, after having waited three to four days for a treatment slot to open. They enter CAP through referrals from the welfare, child welfare, criminal and juvenile justice, mental health, and Medicaid managed care systems.

Treatment Services

The CAP treatment model was developed through a cooperative agreement between the Maryland State Alcohol and Drug Abuse Administration and the Johns Hopkins Bayview Medical Center, with input from the state Medicaid agency. It brings together mental health and addiction treatment, obstetrics/gynecology and family planning, and pediatrics and developmental pediatrics to address the multiple care needs of clients.

The program can accommodate 16 women at one time in residential treatment, 85 women in day treatment (intensive outpatient), and up to 100 in methadone treatment.

Screening and assessment. Women are screened with the Addiction Severity Index (ASI) and, if warranted, with urine toxicology and breath alcohol assay. They also receive a thorough medical exam, including HIV risk assessment.

Outpatient services allow women to move through three levels of care that match their recovery needs and progress. Frequency and intensity of services decrease as women progress in their recovery.

Residential services, where women enter treatment, last for at least seven days. During residential care, clients receive eight hours per day of individual and group counseling, as well as a more thorough medical and obstetrical evaluation.

During the most intensive phase of outpatient services, women attend treatment seven days a week for six hours a day for at least 21 days. Eventually, they decrease their treatment intensity and frequency to a minimum of one day per week. Progress through treatment is monitored with urine drug testing, progress reviews of individual and group therapy, and treatment participation records.

In-treatment support services include on-site child care, transportation to and from the program, and intensive outreach services for clients who miss one or more days of treatment. Clients also receive exit planning, parenting training, and nutritional support (including participation in the federal Women, Infants, and Children (WIC) Program).

Psychiatric consultation, specialized primary care services, and support services for HIV-positive women are also available. Obstetric and gynecological care and family planning are available from a team of four certified nurse midwives who provide all primary care at an on-site clinic, as well as 24-hour coverage for delivery at the hospital center, located nearby.

Clients are assessed for their academic and job skills, which inform their assignments to work or work training activities. They are "hired" to work at the training program, performing activities that are appropriate to their skills level.

Children's services consist of routine well and sick child care, including immunizations and night and weekend coverage for all children in the program. Pediatric care is also provided to children up to age 21 regardless of the mother's continued participation in the program. A children's case manager and assistants, funded through the Baltimore Infants and Toddlers Program, also provide outreach, tracking, in-home developmental screening, and case management services.

Work and work preparation activities are offered as part of the treatment program and were originally funded through a research grant from the National Institute on Drug Abuse (NIDA). The activities occur on-site and concurrently with treatment and last up to 26 weeks.

Clients are assessed for their academic and job skills, which inform their assignments to work or work training activities. They are "hired" to work at the training program, performing activities that are appropriate to their skills level. For example, if a client presents for training with no reading skills, her first training activity would be learning to read. Other clients, with more skills, do data entry and office work.

Every day that clients work a shift and test negative for drugs, they get paid. Payments are in the form of vouchers, which the women can use toward rent, groceries, furniture, and other items.

CAP is in the process of launching an actual business enterprise, which would make welfare treatment clients employees of the university. Clients who have demonstrated sustained abstinence from alcohol and drugs and have the necessary skills will be paid in cash, through a TANF grant diversion program approved by the state welfare agency. Clients would still be tested for drug use.

Aftercare and support services are currently limited. Future goals include transitional housing resources, improved aftercare, and an early child intervention program on site.

Funding for Treatment

Two main sources of funding support treatment services at CAP – Medicaid (90 percent) and the Ryan White CARE Act (5 percent). The other five percent is research funding.

Evaluation & Client Outcomes

A recent evaluation examined outcomes for 100 CAP clients (selected from the first 288 clients admitted between April 1991 and October 1992) and compared them with a control group of 46 pregnant women with alcohol and drug problems who had not received treatment. Findings included:

- Women not in treatment were almost twice as likely to be using drugs at the time of delivery as CAP clients (63.2 percent versus 36.8 percent).
- Infants of CAP clients had better clinical birth outcomes on a number of measures, including birthweight (approximately 400 grams higher) and gestational age at delivery (about three weeks older).
- Infants of women who were not in treatment were more than twice as likely to require hospitalization in the neonatal intensive care unit (NICU) as infants of CAP clients (26 percent versus 10 percent).
- For those infants who needed NICU hospitalization, the average length of stay for those of women who had not received treatment was six times longer than for infants of CAP participants. The lower frequency of NICU admissions and shorter length of stay for CAP clients translated into a net savings of $5,000 per mother-infant pair even after including drug treatment costs.

Center 4 Clean Start
1001 Lake Street
Salisbury, Maryland 21801
410-742-3460

Executive Director: Phyllis J. Richardson

About Center 4 Clean Start

The program is a cooperative project funded and coordinated jointly by the health departments in four local, predominantly rural counties.

Center 4 Clean Start is a three-year-old intensive outpatient alcohol and drug treatment program for women with children located on Maryland's Eastern shore. The program is a cooperative project funded and coordinated jointly by the health departments in four local, predominantly rural counties. The Center's mission is to treat addiction in an environment that promotes well-being and leads to a drug- and alcohol-free lifestyle for pregnant women – before and after delivery – and their children.

Nearly three-quarters of clients arrive at the Center unemployed, and more than half (53 percent) do not have a high school diploma or GED certificate. Almost one-third (28 percent) have a mental illness and about 3 percent are HIV infected. The women enter treatment after referrals from local welfare, child welfare, criminal justice, public health, and mental health agencies. Clients also enter the Center's program from private health care organizations, including managed care organizations.

Treatment Services

The average client stays in intensive outpatient treatment for about 150 days without having to wait for a treatment slot to become available.

Screening and assessment. Clients receive in-depth clinical screening through a variety of instruments, including the Addiction Severity Index (ASI), Substance Abuse Subtle Screening Inventory (SASSI), and Michigan Alcohol Screening Test (MAST). Random urinalysis is also conducted.

Intensive outpatient services include individual and group counseling, referral to residential treatment (for higher intensity care, if needed), and life skills groups. Clients are encouraged to attend self-help groups in the community and required to attend an on-site self-help meeting once a week. Clients participate in treatment activities four days a week from 10 a.m. to 2 p.m.

The Center gives clients an incentive to continue participating in treatment. Clients receive tickets for each day they attend treatment, which they can accumulate to purchase luxury items available from the program. The client with the best attendance record in each month receives a $10 gift certificate to a local K-Mart or Wal-Mart.

In-treatment support services include day care, transportation for clients and their children, and exit planning. Clients also receive parenting training, prenatal health care, and mental health assessment.

The program is co-located with Joseph House, an emergency shelter that can provide sober housing for up to 21 clients, as well as primary health care services, food, and child care.

Work and work preparation activities are optional for clients, and most clients begin them after treatment because they are not ready before. In addition, the day-time treatment schedule can make it difficult to coordinate treatment with work.

But work and working training activities are available off-site for clients who chose to pursue them, as are literacy and GED programs. The Center also hopes to participate in a new state program that is placing vocational training counselors in alcohol and drug treatment programs in rural Maryland and Baltimore City.

Aftercare and support services are limited, and finding clean and sober housing for clients has proven difficult.

Funding for Treatment

Six main sources of funding support treatment services at the Center – state and local appropriations (65 percent), Medicaid (20 percent), food stamps (5 percent), the criminal and juvenile justice systems (5 percent), and federal, state, and local housing agencies (5 percent).

Evaluation & Client Outcomes

Center 4 Clean Start collects both process and outcome measures – including data on work/vocational, employment, earnings, and receipt of public assistance – on its clients. Recent outcomes include:

- 10 percent are engaged in work training at discharge.
- 20 percent of clients are employed at discharge.
- 32 percent of clients are receiving earnings at discharge.
- 10 percent of clients are receiving public assistance or welfare at discharge.

NEW YORK

Catholic Family Center
Hannick Hall
513 West Union Street
Newark, NY 14513
315-331-2300

Program Manager: Valerie Bost

During the day, women receive treatment or participate in the program's integrated vocational, educational or other structured activities, while the children attend local day care centers.

About Hannick Hall

Hannick Hall is a six-month residential treatment program for women, located near Rochester, in the Western part of New York State. Hannick Hall's treatment philosophy is based on a biopsychosocial model of addiction. The goal of treatment is to address the client's medical, psychological and social impairments by providing counseling services and a highly structured, safe and nurturing living environment, with the ultimate aim of empowering women to make healthy choices, develop the skills necessary to live drug-free lives and raise healthy children.

The program serves alcoholic and drug dependent women and their children from around New York State (with the bulk of referrals coming from five surrounding counties). Clients live together in a cooperatively run residence located a few blocks from Hannick Hall's counseling center. During the day, women receive treatment or participate in the program's integrated vocational, educational or other structured activities, while the children attend local day care centers. This arrangement reinforces the program's objective of habilitating and rehabilitating clients, by helping women learn to cope with and take responsibility for meeting the structures and demands of daily living, including going to work, arranging for childcare and maintaining a home for themselves and their children.

Hannick Hall receives referrals from the welfare, child welfare, mental health, and criminal justice systems, as well as from schools and health care providers, though most referrals are made through welfare and child welfare systems. Hannick Hall is a voluntary program; while clients may be under a treatment mandate, the program does not consider itself under any obligation to retain clients who do not abide by the program's rules and cooperative living requirements.

Treatment Services

Hannick Hall has capacity to serve 18 women and seven children at one time. The average length of stay in the program is six months, and the typical amount of time that a client must wait for an admission opening is 30 days.

Screening and assessment. Staff conduct a complete psychological and medical evaluation of clients at admission, including an assessment of their alcohol and drug treatment history and their motivation and willingness to participate in treatment.

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Outpatient services include group, individual, and family counseling at Hannick Hall's treatment facility, which is separate from the residence. Clients take parenting/life skills, addiction, and health education classes and attend at least three AA meetings a week, which are conducted by volunteers (five meetings a week are offered at the program). Mental health evaluation and counseling are also provided (up to 80 percent of clients have co-occurring mental health disorders, with depression the most common diagnosis).

Women's issues are the focus of much of the counseling and educational services provided at Hannick Hall. Clients examine how issues of domestic violence, sexual abuse, and social definitions of the roles of women are related to their drug and alcohol abuse.

Residential services include client responsibility for cooking and cleaning for themselves, as well as for most aspects of operating and governing the house. Through these responsibilities, clients learn daily living and communication skills and have the opportunity to practice the conflict resolution, anger management, and parenting techniques they have learned in counseling sessions and classes. Clients are also given the opportunity to help and support each other's recovery.

After approximately 60 to 90 days in the program, clients begin receiving vocational services, with the goal of gaining skills and experience in the workplace.

Women are responsible for arranging for their own medical appointments, day care, transportation, and other needs. If clients fail to do so, the program allows "the logical and natural consequences to occur," which teach clients how to overcome their social dysfunctions and develop the ability to manage their own lives. In this way, the life skills they acquire are directly related to developing work skills and raising healthy children.

Work and work training activities include vocational/educational and other support services. After approximately 60 to 90 days in the program, clients begin receiving vocational services, with the goal of gaining skills and experience in the workplace. Through a cooperative arrangement with BOCES, a state/county remedial education provider, clients receive educational testing, learning disabilities diagnosis, GED preparation, and special education on-site. Clients are also assessed for eligibility for a state-run vocational rehabilitation program for the disabled.

A majority (80 percent) of Hannick Hall's clients have been chronically unemployed throughout their lives. To gain work experience and develop good work habits, clients must arrange a volunteer "field placement" or internship while they are in Hannick Hall, which is tailored to their individual skills and interests. In the past, for example, clients have worked in hospitals, law offices, and florist shops.

In-treatment support services include child care, which is provided off-site through two day care agencies that have been trained by Hannick Hall about the needs of children with parents who have alcohol and drug problems.

Aftercare and support services are provided through referral to community residences or supportive living arrangements, and clients are recommended to continue to receive one year of outpatient treatment.

Funding for Treatment

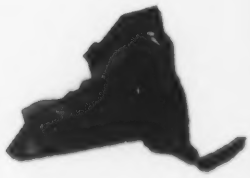
Hannick Hall receives most of its Funding through the New York State Office of Alcohol and Substance Abuse Services (OASAS). The program also receives support through TANF (10 percent), food stamps (1 percent), and private health insurance (1 percent).

Evaluation and Client Outcomes

Hannick Hall has not had the resources to conduct a formal outcome evaluation of its clients' post-treatment success. The program reports data to OASAS and has informally tracked outcomes of past clients.

Project Return Foundation, Inc.
Dreitzer Women and Children's Program
315 East 115th Street
New York, New York 10029
212-348-4480

Program Director: Sharon Dorr



About the Dreitzer Women and Children's Program

The Project Return Foundation's Dreitzer Women and Children's Program is a 12- to 18-month residential treatment program located in New York City for women who are diagnosed both with alcohol and drug problems and mental illness and their children (up to age three). The goal of the program is to promote a sober lifestyle and good mental health by enhancing each woman's level of functioning as an individual and as a mother, while keeping her and her child together.

The majority of the women in the program have been victims of domestic violence (70 percent) and have not graduated from high school or have their GED (60 percent).

The majority of the women in the program have been victims of domestic violence (70 percent) and have not graduated from high school or have their GED (60 percent). Virtually all the women in the program have had a child or children placed with child protective services (96 percent), have a history of relapse (100 percent), and have been chronically unemployed (96 percent). One-quarter (25 percent) have had a felony conviction for drug possession, use, or sale; the same percentage have been mandated into treatment as a condition of parole or probation. About 3 percent are HIV infected.

Women must be at least 18 years old to receive services at the program. They must also be willing to enter the program with one child, newborn to three years of age, and demonstrate the potential to improve their functional skills. Women cannot enter the program on methadone maintenance. The program receives referrals from the welfare, child welfare and criminal justice systems, as well as from private health care providers and the mental health system.

Treatment Services

The Dreitzer Women and Children's Program describes itself as different from the traditional therapeutic community program, in that it is more "fluid" and not as time-driven. The program can serve 25 women and 25 children in residential care. Almost all of the services are provided on-site.

Screening and assessment. Women undergo an intensive assessment before they are admitted into the program. Clients are screened using the Parenting Stress Index, Battelle Development Inventory (child), Self-Report Family Inventory, and Parenting Self-Assessment.

Before an intake interview is scheduled, application materials are requested, including the results of a recent mental status evaluation, a psychosocial evaluation, and recent

medical examinations of the mother and child. If the documentation is accurate and complete, an intake interview, which can take three to four hours, is scheduled. The intake interview assesses applicants' motivation for treatment and psychiatric stability. The mother and child's interaction is also assessed for the mother-child bond, parenting skills, and any evidence of neurological problems.

Clients' names are not put on the waiting list until the intake process is complete. In addition, the necessary medical documentation for the mother and child, court approval if necessary, and approval for welfare entitlements must be received before a client is put on the waiting list. Once an applicant is placed on the waiting list, the average time spent waiting for a treatment slot to open is 30 days.

Women participate in "World of Work" group sessions and are given different job function assignments.

Screening also takes places at a case conference review, held after the client has completed nine months of treatment.

Residential services include weekly individual counseling sessions and daily therapeutic groups that address a broad range of issues, including alcohol and drug use and history, relapse, and relationships and family dynamics in recovery. The women attend self-help (AA/NA) meetings and participate in mental health groups where they deal with both their mental health and alcohol and drug issues.

Counselors provide crisis intervention services, network with outside agencies, and advocate for the women and children. House managers make sure the facility is secure, do crisis intervention, and monitor who is entering and leaving the building.

Work and work preparation activities are required as part of treatment, occur concurrently with treatment, and take place both on and off the program site. But clients do not work while in the program.

The program offers a full range of vocational services, such as testing, assessment, and placement. Testing focuses on achievement and occupational interest. Assessment of each woman's potential to succeed in a chosen career takes into account test results, past education, previous work experiences, and areas of interest.

Women participate in "World of Work" group sessions and are given different job function assignments. The program also provides linkages to literacy and GED programs in the community, in addition to other external education, training, or employment programs.

In-treatment support services include a family life unit, which was established to help women address parenting and family issues, with support from a family life coordinator, child development specialist, and senior child specialist. The unit examines the influences that affect parenting styles and helps women develop coping skills for daily living in group and individual sessions.

Clients also have access to a medical department, consisting of a psychiatric registered nurse, a licensed practical nurse, a consultant psychiatrist, a consultant pediatrician, and a consultant general practitioner. The department clears all applicants into the program, manages all prescribed medications, evaluates the mental health of all residents, evaluates the physical health of both adults and children, makes referrals to other agencies, and monitors all medical emergencies.

A Social Services Department helps clients apply for public assistance, Medicaid, and permanent housing, as well as manage their court appearances, interactions with child protective and foster care agencies, and other types of advocacy or referral services they need.

Children's services include daily activities for three age groups – infants, walkers/crawlers, and toddlers – organized by the Child Specialist Department. Activities focus on the children's growth and their different developmental stages. Areas of concentration include motor development, hand-eye coordination, social development, and play.

Child specialists keep weekly logs and file monthly reports on each child's progress. If a child shows signs of developmental delay, referrals to outside agencies are made for early intervention. The mothers also participate in some of the activities when their treatment schedules permit.

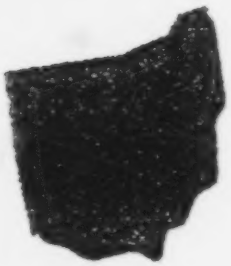
Aftercare and support services. After completing residential treatment, mother and child are referred to an off-site continuing care program and begin to re-integrate into the community. Project Return Foundation is planning to build a supportive housing facility nearby for women coming out of residential treatment.

Funding for Treatment

The program is funded by two main sources – the New York State Office of Alcoholism and Substance Abuse Services (50 percent) and the federal Department of Housing and Urban Development (50 percent).

Evaluation and Client Outcomes

The program uses both process and outcome measures to gauge client success, including work and vocational outcomes. Aggregated outcome data, however, are not available.



OHIO

Amethyst
527 South High Street
Columbus, Ohio 43215
614-242-1284

Executive Director: Virginia O'Keeffe

About Amethyst

Amethyst's mission is to provide alcohol and drug treatment, supportive housing, intensive case management, and education/employment training for homeless and low-income women and their children.

Amethyst is a 15-year-old alcohol and drug treatment program founded by women in recovery to serve pregnant and parenting women with alcohol and drug problems. It has grown from serving three clients with one volunteer in a donated house in 1984 to serving more than 150 women and their children in 115 housing units in 1998.

Amethyst's mission is to provide alcohol and drug treatment, supportive housing, intensive case management, and education/employment training for homeless and low-income women and their children. The goal of the program is to assist all clients in achieving lifelong sobriety, permanent housing, and economic stability through the development of necessary life skills.

The average age of an Amethyst client is 27. The average client has completed her education only through the 10th grade, and most have no work experience.

Amethyst's clients are predominantly African-American (70 percent). Staff reflect the racial and ethnic makeup of clients, with 75 percent of direct services staff being African-American. Spanish-speaking staff are available for Latina clients. Many staff also are formerly homeless and in recovery.

Amethyst staff say they have seen a change in the clients seeking services in the last several years. Women are younger, are addicted to multiple substances, began using alcohol and drugs at an earlier age, are more likely to have co-existing mental health problems, and are also involved in several other systems, including child protective, criminal justice, and child support enforcement.

Treatment Services

Amethyst provides a full continuum of care ranging from entry level through aftercare, during which clients move through progressive levels of recovery and independence.

Amethyst can accommodate more than 150 women and their children each year. In Fiscal Year (FY) 1998, Amethyst housed 158 women and their 175 children throughout the city of Columbus. Women stay an average of 365 days and do not have to wait for a treatment slot to open. Any waiting time is related to client readiness to be in treatment, not housing capacity. By the time they finish orientation, most clients have achieved two weeks of sobriety.

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Screening and assessment. Women receive in-depth assessment of their problems, needs, and strengths. Clinical screening is conducted with Addiction Severity Index (ASI).

Outpatient services are available to clients after completion of the residential portion of the program.

Residential services are provided in a therapeutic community model that includes residential sober living. Amethyst leases 115 housing units at multiple sites, each of which has a resident manager responsible for providing support and supervision around the clock to the women and families living there.

During the first six months of treatment, women participate in programming five days a week for an average of four to five hours each day. The curriculum includes group, individual, and family counseling, education, case management, and life skills training. Clients are also required to attend 12 Step (AA/NA) meetings each week.

Later phases of treatment involve more educational, work, and work readiness activities, with group meetings held in the evening to accommodate clients' work and school schedules. Later phases of treatment also include focus on relapse prevention, time and financial management, and personal challenges in recovery.

In-treatment support services include child care, transportation, clean and sober housing, parenting training, and exit planning. Therapeutic day care is available for children ages 0 to 6 through a partnership with the local YWCA. Amethyst also collaborates with area health providers for prenatal, postpartum, and Healthy Start services for pregnant clients and their newborns and provides early intervention programming for the older children of clients.

Children's services are a high priority at Amethyst, and the program just opened an after-school drop-in center for children at one of its residential sites. In addition to therapeutic day care for children ages 0 to 6, Amethyst provides school-age children with alcohol and drug abuse prevention education and mentors from the local chapter of Big Brothers/Big Sisters.

For the first time in 1998, Amethyst ran its own therapeutic summer programming, including violence prevention and education opportunities for school-age children. The program provided prevention and early intervention for violence against self (drug and alcohol abuse) and against others (gangs and family/domestic). The program also provided children with daily exercise, fun, and nutrition, as well as regularly scheduled enrichment activities and field trips.

Work and work preparation activities are emphasized at Amethyst, with the program qualifying as a certified job site under the county's Department of Human Services rules. Work that clients perform at the program helps satisfy their work requirements under TANF.

Staff are working on several fronts to increase work and work training opportunities for clients, including forging a partnership with a new work training program in the community and forging relationships with local employers.

Work and work preparation activities are emphasized at Amethyst, with the program qualifying as a certified job site under the county's Department of Human Services rules.

Counselors give students and their parents information and advice about how to prepare for college, including accumulating the right course credits; maintaining high grades; engaging in co-curricular activities; and mapping a plan to select a college, gain admission, and finance a college education. Students may also need other counseling, such as academic, career, personal, family, substance abuse, or mental health services in order to succeed.

Part of a counselor's role is to get parents involved in the education process. Research shows that parents with substantial money and education are more likely than others to be involved in selecting their children's courses, and that Hispanic parents are less likely to fall into this group. Students whose parents participate in the decision-making process also are more likely to be enrolled in college preparatory classes (Oakes & Guiton, 1995; Yonezawa & Oakes, 1999). Although Hispanic parents set high expectations and goals for their children, many need more knowledge about options to guide their children toward promising postsecondary education and career choices (Cooper, Denner, & Lopez, 1999).

GEARing Up for Success

GEAR UP (Gaining Early Awareness and Readiness for Undergraduate Programs), a research-based program authorized under Title II of the Higher Education Act of 1998 and administered by the U.S. Department of Education, supports early college preparation and awareness activities at the local and state levels. GEAR UP awards competitive multiyear grants to locally designed partnerships among colleges, low-income middle schools, and at least two other partners (e.g., community organizations, businesses, state education agencies, parent groups, and nonprofit organizations) to increase the college entry rates for low-income youth, including Hispanic students.

Local GEAR UP partnerships often incorporate proven strategies for helping low-income youth increase their chances of attending college, informing students and their parents about college options and financial aid, encouraging students to take college-preparatory classes, working with all students in a grade level, and providing a group of sixth- or seventh-graders with services through high school graduation. GEAR UP services may include mentoring, tutoring, counseling, after-school programs, summer academic and enrichment programs, and college visits. For example, the University of Connecticut is working with Louis Batchelder School in Hartford to provide its sixth- and seventh-graders and their families, many of whom are Hispanic, with counseling, tutoring, and parent education. State GEAR UP providers similarly provide low-income students with activities to make them aware of college opportunities early in their schooling, better academic support, information about paying for college, and scholarships.

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Rural Women's Recovery Program
Health Recovery Services
P.O. Box 724
Athens, Ohio 45701
740-593-6152

Administrative Director: Karen Peck
Clinical Director: Janis France

About the Rural Women's Recovery Program

The Rural Women's Recovery Program (RWRP) is an nine-year-old residential alcohol and drug treatment program for women ages 18 and older with or without children. The program can accommodate up to five children under the age of 5. Located in the hills of southeastern Ohio, close to the West Virginia border, RWRP is a peaceful setting for recovery.

Located in the hills of southeastern Ohio, close to the West Virginia border, RWRP is a peaceful setting for recovery.

RWRP is a part of Health Recovery Services (HRS), a comprehensive treatment program in the city of Athens. Since 1975, HRS has provided a range of alcohol and drug treatment services, including residential treatment for adolescents, intervention programs for youthful offenders, and prevention programs for children from pre-school through grade 12.

RWRP takes a holistic approach to treatment that focuses on the physical, emotional, and spiritual aspects of addiction and recovery. RWRP's family-centered approach to treatment welcomes and accommodates clients' children into the treatment setting. The main goal of the program is to help women build the recovery skills they need to return to the community and manage their lives without alcohol or drugs.

Staff say that RWRP is a last stop for many of their clients. Women are only eligible for residential services available there if they already failed at outpatient treatment. Many are required to be in treatment by the criminal justice or child welfare system.

Treatment Services

RWRP can accommodate up to 12 women plus their children in residential treatment. The program takes referrals from all over Ohio. At any given time, RWRP has seven to eight women on a waiting list, some of whom can wait up to several weeks for a treatment slot to open.

Screening and assessment. Women receive in-depth assessment of their problems, needs, and strengths. Clinical screening is conducted with a biopsychosocial assessment.

Residential services. When RWRP opened in 1990, residential services were available for up to 12 months. Recently, to try to accommodate more clients and stay financially viable, RWRP has decreased the residential length of stay to 75 days for women with children.

During residential care, women learn about addiction and start their recovery by learning about the disease model of addiction. Individual and group therapy is also provided to address the women's drug and alcohol problems, as well as for other common co-occurring problems, such as mental illness, history of sexual abuse or domestic violence, and

RWRP recently began collaborating with the "Work Now" program, a vocational readiness program funded by the Ohio Rehabilitation Services Commission (ORSC) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS).

eating disorders. Clients can live in treatment as individuals or in family units, which are available to women with children under the age of five.

In-treatment support services include child care, transportation, clean and sober housing, exit planning, and parenting training. Children receive a range of services, including care and education to help the family begin the recovery process together. Exit planning helps clients prepare for working, find appropriate child care, and make connections with others in recovery in their communities.

Outpatient and aftercare services. After residential care, the women move into aftercare on an outpatient basis. Aftercare, which includes monthly alumni groups and case management services, is geared toward transition back into the community and relapse prevention. The services are operated by RWRP's parent agency, HRS. Post-treatment clean and sober housing is not available in the community.

Work and work preparation activities are considered secondary to clients' recovery process at RWRP, however, clients can and do participate in a variety of work and work preparation activities during both residential treatment and aftercare.

During treatment, clients participate in groups that help them learn money management, living, and interviewing skills. RWRP also arranges for clients to participate in GED classes in the community and attend career days at the local college, Ohio University.

RWRP also recently began collaborating with the "Work Now" program, a vocational readiness program funded by the Ohio Rehabilitation Services Commission (ORSC) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS). One of the two target populations is women receiving public assistance who have alcohol and drug problems. Clients participate in the program for three hours three times per week.

Clients accepted into the program receive intensive case management services while they participate in a four- to six-week job readiness program. Activities focus on life and personal development skills, including conflict resolution, time management, dealing with stress, resume writing, and interview skills.

Funding for Treatment

RWRP accepts clients regardless of their ability to pay and RWRP relies on a variety of funding sources to support women in treatment. These sources include: Medicaid (33 percent), federal Substance Abuse Block Grant (31 percent), and state and local funding (36 percent).

Evaluation & Client Outcomes

According to RWRP staff, many clients are successful in gaining and maintaining recovery. Staff do follow-up calls for a certain period after discharge to ascertain if clients are staying sober, if they are attending aftercare appointments, if they are attending AA/NA meetings, and to give them support. The mobility of the client population, however, makes it difficult to conduct long-term tracking.

RWRP tracks both process and outcome measures, but none related to employment or receipt of public assistance. But no aggregate outcome data are currently available.

The following are available from the Legal Action Center.

"A Fact Sheet for Policy Makers – Welfare Reform: How States Can Use TANF Funding to Pay for Alcohol & Drug Treatment," September 1998. Fax requests to 202-544-5712.

Making Welfare Reform Work: Tools for Confronting Alcohol and Drug Problems Among Welfare Recipients, September 1997. Fax requests to 202-544-5712.

Welfare As We Know It Now: What New York's New Welfare Laws Mean for People with Criminal Records, Substance Abuse Histories, and HIV/AIDS. October 1998. Fax requests to 212-675-0286.

The following publications are available from the National Clearinghouse on Alcohol and Other Drug Information, 1-800-729-6686. Website: http://www.health.org

CSAP Implementation Guide – From the Source: A Guide for Implementing Perinatal Addiction Prevention and Treatment Programs, U.S. Department of Health and Human Services, Center for Substance Abuse Prevention, 1996.

Drug Addiction Research and the Health of Women, U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, 1998.

National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs 1996, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 1997.

Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 1995.

Pregnant, Substance-Using Women (TIP #2), U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 1993.

Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases (TIP #11), U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 1994.

Substance Abuse and Mental Health Source Book, 1998, U.S. Department of Health and Human Services, 1998.

Substance Abuse Treatment and Domestic Violence (TIP #25), U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment,1997.

Women and Alcohol: Issues for Prevention Research (Research Monograph 32), U.S. Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism, 1996.

The following are other publications available from other sources:

Allen, MaryLee and Jamila Larson, **Healing the Whole Family: A Look at Family Care Programs**, Children's Defense Fund, 1998.

Burden, Dianne S. and Naomi Gottlieb, editors. **The Woman Client: Providing Human Services in a Changing World**. Tavistock Publications, New York, 1987.

Davis, Liane V., editor. **Building on Women's Strengths: A Social Work Agenda for the 21st Century**. The Hawthorn Press, New York, 1994.

Drabble, Laurie. "Elements of Effective Services for Women in Recovery: Implications for Clinicians and Program Supervisors," *Journal of Chemical Dependency Treatment*, Volume 6 (1996), pp. 1-21.

Finkelstein, N., et. al. **Gender-Specific Substance Abuse Treatment**. Alexandria, VA: National Women's Resource Center for the Prevention and Treatment of Alcohol, Tobacco, and Other Drug Abuse and Mental Illness, 1997.

Jansson, Lauren, *et. al.* "Pregnancy and Addiction: A Comprehensive Care Model," *Journal of Substance Abuse Treatment*, Volume 13 (1996), pp. 321-329.

Mathematica Policy Research, **Ancillary Services to Support Welfare-to-Work**, June 1998.

National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, **Welfare Reform: Issues and Implications for Children and Families Who Need Mental Health or Substance Abuse Services**, October 1998.

Young, Nancy K. and Sidney L. Gardner, **Implementing Welfare Reform: Solutions to the Substance Abuse Problem**, Children and Family Futures (Irvine, California) and Drug Strategies (Washington, DC), 1997.

State Decisions on Ban on TANF and Food Stamps For Individuals Convicted of Drug Felonies

(As of February 1999)

States That Have Denied Benefits Entirely (48%)

Alabama
Arizona
California
Delaware
Georgia
Idaho
Indiana
Kansas
Kentucky
Maine
Massachusetts
Mississippi
Missouri
Montana
Nebraska
New Mexico
North Dakota
Pennsylvania
South Dakota
Tennessee
Texas
Virginia
West Virginia
Wyoming

States That Have Modified the Ban (36%)

Alaska
Arkansas
Colorado
Florida
Hawaii
Illinois
Iowa
Louisiana
Maryland
Minnesota
Nevada
New Jersey
North Carolina
Rhode Island
South Carolina
Utah
Washington
Wisconsin

States That Have Opted Out Entirely (16%)

Connecticut
Michigan
New Hampshire
New York
Ohio
Oklahoma
Oregon
Vermont

Source: Staff research on state legislation, responses to a 1997 Legal Action Center survey of 50 state welfare directors and 50 state alcohol and drug agency directors, and information from the National Association of State Alcohol and Drug Abuse Directors and National Governors' Association Center for Best Practices.

Appendix II

State Decisions on Screening and Testing Welfare Recipients for Alcohol and Drug Problems

(As of February 1999)

States That Will Require Urine Drug Tests of All Welfare Recipients (2%)

Michigan

States That Require Urine Drug Tests of Individuals with Drug Felony Convictions (8%)

Minnesota
New Jersey
South Carolina
Wisconsin

States With Other Screening Plans (52%)

Arkansas
California
Colorado
Delaware
Florida
Georgia
Illinois
Indiana
Kansas
Kentucky
Louisiana
Maine
Maryland
Nevada
New Hampshire
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
South Dakota
Utah
Vermont
Washington

States With No Screening Plans (32%)

Alabama
Alaska
Arizona
Connecticut
Hawaii
Idaho
Iowa
Massachusetts
Missouri
Montana
New Mexico
Rhode Island
Tennessee
Texas
Virginia
Wyoming

States That Will Rely on Self-Declaration of Being Drug-Free (6%)

Mississippi
Nebraska
West Virginia

Source: Staff research on state legislation, responses to a 1997 Legal Action Center survey of 50 state welfare directors and 50 state alcohol and drug agency directors, and information from the National Association of State Alcohol and Drug Abuse Directors and National Governors' Association Center for Best Practices.

Programs Profiled By State

California

Center Point (San Rafael)
La Casita de las Mamas (Downey)
Patterns (Hawthorne)
Project Pride (Oakland)
Prototypes (Pomona)
Tarzana Treatment Center (Tarzana)

Florida

PAR Village (St. Petersburg)
The Village (Miami)

Illinois

Haymarket Center (Chicago)
New Leaf (Peoria)
Rosecrance (Rockford)
The Women's Treatment Center (Chicago)

Maine

Crossroads for Women (Windham)

Maryland

Avery House (Rockville)
Center for Addiction and Pregnancy (Baltimore City)
Center 4 Clean Start (Salisbury)

New York

Hannick Hall (Newark)
Project Return (New York City)

Ohio

Amethyst (Columbus)
Rural Women's Recovery Program (Athens)

Appendix IV

Matrix of Information Domains Explored

Changes in the Law	Potential Effects on Treatment Programs	Potential Effects on Clients/Consumers
Ban on TANF for individuals with drug felony convictions Ban on food stamps for individuals with drug felony convictions	Increase/decrease/no change to: funding client caseload criminal justice referrals treatment slots available staff size	Increase/decrease/no change to: ability to afford treatment ability to provide for family involvement with CPS criminal justice involvement
Ban on TANF for individuals violating a condition of their parole or probation Ban on food stamps fro individuals violating a condition of their parole or probation	Increase/decrease/no change to: funding client caseload criminal justice referrals treatment slots available staff size	Increase/decrease/no change to: ability to afford treatment ability to provide for family involvement with CPS criminal justice involvement
Work requirements	Change/no change to: treatment protocol to incorporate work training activities treatment protocol to incorporate work activities Increase/decrease/no change to: linkages with external employment training providers linkages with employers	Increase/decrease/no change in time available for treatment Interfere/not interfere with treatment plan Improve/not improve treatment experience
Time limit on cash assistance	Increase/decrease/no change to: funding client caseload criminal justice referrals treatment slots available staff size	Increase/decrease/no change to: ability to afford treatment ability to provide for family involvement with CPS criminal justice involvement
Sanctions for non-compliance with work requirements, including sanctions on Medicaid	Increase/decrease/no change to: funding client caseload criminal justice referrals treatment slots available staff size	Increase/decrease/no change to: ability to afford treatment ability to provide for family involvement with CPS criminal justice involvement

Survey Instrument

Legal Action Center
Welfare Model Project

Program Name: _____

Address: _____

_____

Phone Number: _____

Program Director: _____ _____

Please complete the attached questionnaire and fax it to Gwen Rubinstein at (202) 544-5712.

Questions: Call (202) 544-5478.

Feel free to provide any other information you see fit.

Survey of Treatment Programs Serving Welfare Clients

Characteristics of Welfare Treatment Caseload	***Percent (%)***
What percent of your welfare treatment caseload:	
Has had a felony drug conviction for use, possession, or distribution since 8/22/96 (or any other date your state has adopted as the effective date)	
Is in treatment as a condition of parole or probation	
Has a child or children placed with child protective services	
Is a victim of domestic violence	
Is addicted to alcohol	
Is addicted to drugs	
Is addicted to both alcohol and drugs	
Has a history of relapse	
Is chronically unemployed	
Has not graduated from high school and do not have GED	
Has low literacy skills	
Has co-occurring mental illness/disorder	
Is HIV positive or have AIDS	

Other Characteristics	***Number***
Number of children	
Average treatment length of stay (in days)	
Average time spent waiting for a treatment slot to open (in days)	

Treatment Components	***Yes***	***Number of Slots***
What treatment modalities are available in your program (check all that apply)		
Methadone		
Non-hospital residential		
Outpatient		
Day treatment		
Other (please specify)		
Aftercare available		
Assessment Tool Used (please specify)		

Treatment Referral Sources	Yes	No
Does your program receive referrals from:		
Welfare agency		
Child welfare agency		
Criminal/juvenile justice agency		
Public health agency		
Private health care provider(s)		
Education system		
Mental health system		
Managed care organization(s)/provider(s)		
Other – Please specify		

Work and Work Training Components	Yes	No
How does your program help prepare clients for work?		
Work/vocational training offered as part of treatment program but not required		
Work/vocational training required as part of treatment		
Work/vocational training occurs concurrently with treatment		
Work/vocational training occurs consecutively with treatment		
Work/vocational training occurs on-site		
Work/vocational training occurs off-site		
Work activities required to graduate from treatment		
Linkages to literacy program available		
Linkages to GED programs available		

Support Components	Yes	No
Which of the following support services are available to welfare treatment clients?		
Affordable child care available during treatment		
Affordable transportation available during treatment		
Clean and sober housing available to treatment clients		
Clean and sober housing available to post-treatment clients		
Exit planning provided		
Parenting training provided		

Funding Sources Supporting Treatment for Women on Welfare	***Yes***	***(%) of Budget***
Which of the following sources of funding support women on welfare in your treatment program?		
Medicaid		
SAMHSA/Substance Abuse Block Grant		
SAMHSA/CSAT or CSAP Categorical Program (such as RWC or PPWI)		
Federal categorical mental health program		
TANF (welfare)		
Food stamps		
Welfare-to-Work (through a Private Industry Council)		
State/local appropriations/funding		
Criminal/juvenile justice system		
Self-pay		
Private health insurance		
Ryan White CARE Act		
State/local public housing agency		

Evaluation Criteria Analyzed	***Yes***	***No***
What type of evaluation process do you use to judge the success of your programs serving women on welfare?		
Process measures only		
Outcome measures only		
Both process and outcome measures		
Work-related outcomes measured		
Work/vocational		
Employment		
Earnings		
Receipt of public assistance/welfare		

Treatment Effects of Welfare Reform	Yes	No
Has your program experienced any of the following potential effects of welfare reform?		
More referrals from state or local welfare agencies?		
Problems having treatment for welfare recipients authorized or paid for?		
Client denials of welfare eligibility as a result of drug felony convictions?		
Client denials of welfare eligibility as a result of parole or probation violations?		

Predicted Effects of Welfare Reform	Increase	Decrease	Stay About the Same
How do you expect welfare reform will affect the following aspects of your program?			
Number of clients			
Revenue			
Number of publicly funded treatment beds/slots			
Staff size			
Program Size			

Program Funding Sources

Program*	Medicaid	Substance Abuse Block Grant	SAMHSA Categ.	TANF	Food Stamps	Welfare-to-Work	State/ Local	Crime/ Juv. Justice	Ryan White CARE Act	Priv. Ins.	Self-pay	Public Housing
Center Point	0.00	0.00	65.00	0.00	0.00	0.00	35.00	0.00	0.00	0.00	0.00	0.00
East Bay	0.00	0.00	60.00	4.00	2.00	0.00	0.00	34.00	0.00	0.00	0.00	0.00
La Casita	0.00	0.00	94.00	3.00	2.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00
Patterns	0.00	0.00	0.00	14.00	0.50	0.50	75.00	0.00	0.00	0.00	10.00	0.00
Prototypes	6.00	28.00	11.00	10.00	2.00	0.00	10.00	16.00	6.00	0.00	1.00	11.00
Tarzana	0.00	50.00	0.00	40.00	0.00	0.00	0.00	0.00	5.00	0.00	5.00	0.00
PAR Village**	5.00	3.00	0.00	0.00	1.00	0.00	1.00	3.00	2.00	1.00	12.00	0.00
The Village	5.00	0.00	0.00	5.00	2.00	0.00	88.00	0.00	0.00	0.00	0.00	0.00
Haymarket	0.00	0.00	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rosecrance	25.00	20.00	0.00	20.00	0.00	0.00	20.00	0.00	0.00	15.00	0.00	0.00
TWTC	75.00	0.00	10.00	0.00	0.00	0.00	0.00	0.00	5.00	10.00	0.00	0.00
Crossroads	40.00	30.00	0.00	0.00	5.00	0.00	10.00	0.00	0.00	10.00	5.00	0.00
Avery House	0.00	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
CAP	90.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.00	0.00	0.00	0.00
Center 4 Clean Start	20.00	0.00	0.00	0.00	5.00	0.00	65.00	5.00	0.00	0.00	0.00	5.00
Project Return	0.00	0.00	0.00	0.00	0.00	0.00	50.00	0.00	0.00	0.00	0.00	50.00
Hannick Hall	0.00	0.00	0.00	10.00	1.00	0.00	82.00	0.00	0.00	1.00	0.00	0.00
Amethyst	14.00	0.00	0.00	0.00	0.00	0.00	65.00	0.00	0.00	0.00	0.00	20.00
RWRC	33.00	31.00	0.00	0.00	0.00	0.00	36.00	0.00	0.00	0.00	0.00	0.00
Average	16.47	13.79	17.89	5.58	1.08	0.03	28.26	3.05	1.21	1.95	1.79	4.53

*Does not include New Leaf for Women, for which financial data were not available.
**Does not add up to 100 because the program receives funds from sources not listed here.

Welfare Client Profiles by Program

	% w/Fel. Drug Conviction	% in Tx. Parole/ Probation	% Invol. w/ Child Prot. Sv.	% Victim of Dom. Vio.	% w/ History of Relapse	% Chronic. Unempl.	%w/o HS Dip. or GED	% w/ Mental Illness	% HIV Positive
Center Point	33.00	75.00	85.00	83.00	100.00	100.00	56.00	30.00	2.00
East Bay	30.00	30.00	85.00	70.00	90.00	90.00	85.00	40.00	3.00
La Casita	15.80	2.30	10.00	3.00	80.00	99.60	83.00	16.00	0.00
Patterns	20.00	15.00	48.00	60.00	100.00	85.00	85.00	30.00	0.00
Prototypes	na	39.30	40.00	39.20	65.50	97.50	52.50	13.70	9.90
Tarzana	20.00	30.00	60.00	60.00	45.00	65.00	35.00	25.00	20.00
PAR Village	na	28.00	na	na	69.00	5.00	29.00	27.00	na
The Village	20.00	15.00	70.00	85.00	75.00	85.00	60.00	40.00	25.00
Haymarket	na	na	70.00	na	85.00	70.00	70.00	30.00	na
Rosecrance	5.00	60.00	5.00	75.00	78.00	72.00	59.00	49.00	2.00
TWTC	na	16.00	50.00	75.00	60.00	100.00	90.00	75.00	0.00
Crossroads	12.00	12.00	na	79.00	80.00	70.00	40.00	20.00	0.00
Avery House	25.00	10.00	80.00	20.00	70.00	100.00	15.00	10.00	0.00
CAP	34.00	19.00	5.00	27.00	90.00	100.00	48.00	3.00	10.00
Center 4 Clean Start	26.00	26.00	15.00	na	na	76.00	53.00	28.00	3.00
Project Return	25.00	25.00	96.00	70.00	100.00	96.00	60.00	100.00	3.00
Hannick Hall	5.00	20.00	95.00	50.00	100.00	80.00	50.00	80.00	1.00
Amethyst	na	5.00	25.00	95.00	100.00	100.00	na	80.00	5.00
Rural Women's Ctr.	29.60	31.20	12.50	65.60	100.00	56.20	40.60	70.30	0.00
Average	15.22	23.04	46.38	47.84	74.38	81.17	53.30	38.35	4.20

na=not available

Key Aspects of State Welfare Policies Toward Recipients with Alcohol and Drug Problems

(For States With Programs Profiled in this Report)

	California	Florida	Illinois	Maine	Maryland	New York	Ohio
Population[1]	29,760,021	12,937,926	11,896,000	1,227,928	5,094,000	18,137,000	10,847,115
Welfare Program	California Work Opportunity and Responsibility to Kids (CALWORKS)	Work and Gain Economic Self Sufficiency (WAGES)	Temporary Assistance for Needy Families (TANF)	Welfare to Work Program	Family Investment Program (FIP)	Family Assistance Program (FAP)	Ohio Works First
Welfare Caseload[2]	2,019,702	254,042	482,650	40,055	128,806	888,725	341,839
Safety Net Program	Counties provide general relief and health care	None	None	None	Yes	Voucher program	None
Screening for alcohol and drug problems	All welfare applicants	3-region pilot program will drug test recipients identified by other screening	Intake workers identify barriers to work and link recipients to services.	Yes	Required as part of initial health screen by Medicaid managed care organizations	9-item screen administered by caseworker. Fuller assessment by credentialed counselor, if necessary.	All applicants.

[1] Census data from July 1997.

[2] As of June 1998, according to data from the U.S. Department of Health and Human Services, Administration on Children and Families.

Treatment requirements	Those who need it may be referred, required to attend, and monitored for compliance.	State department of labor may make treatment a work requirement	Those needing treatment are required to attend and monitored for compliance.	No mandatory treatment	Benefits for those who do not comply with available treatment will be reduced by their portion of the total grant. Children's portion will be paid to a third party.	Individuals with alcohol and drug problems are required to enter available treatment and monitored for compliance.	No mandatory treatment provided.
TANF eligibility of individuals with drug felony convictions	Not eligible.	Benefits denied to individuals convicted of felonies for drug trafficking. Individuals convicted for use and possession are eligible.	Those with felonies for trafficking are not eligible. Those with other drug felonies lose eligibility for 2 years if they are not in a treatment or aftercare program.	Not eligible.	Eligible	Eligible	Eligible
Admission of women to publicly funded treatment	55,878	17,157	25,407	2,118	9,903	38,673	18,560
Urine drug testing	None	(See above)	None	None	None	None	None

Fiscal Year 1994 data from the National Association of State Alcohol and Drug Abuse Directors.

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Relationship between treatment and work requirements	Individuals may receive treatment for 6 months without participating in work; after 6 months, treatment continues but with work activities.	None specified. State may require treatment as part of a work program.	Treatment counts as work.	Treatment is not a required condition of eligibility	Recipients who comply with treatment can be exempt from work, as determined by the local welfare agency and the treatment provider or managed care organization.	Those unable to work due to an alcohol or drug problem are exempt from work but must participate in available treatment to receive benefits, with re-evaluation after 90 days.	Individuals do not have to receive alcohol or drug treatment to become work-eligible.

Sample General Treatment Admission Criteria

(Source: Haymarket Center, Chicago)

Minimum Age Allowed: 18 years of age

Psychological Status: Patient currently experiencing any of the following must be cleared by the program's clinical psychologist prior to admission:

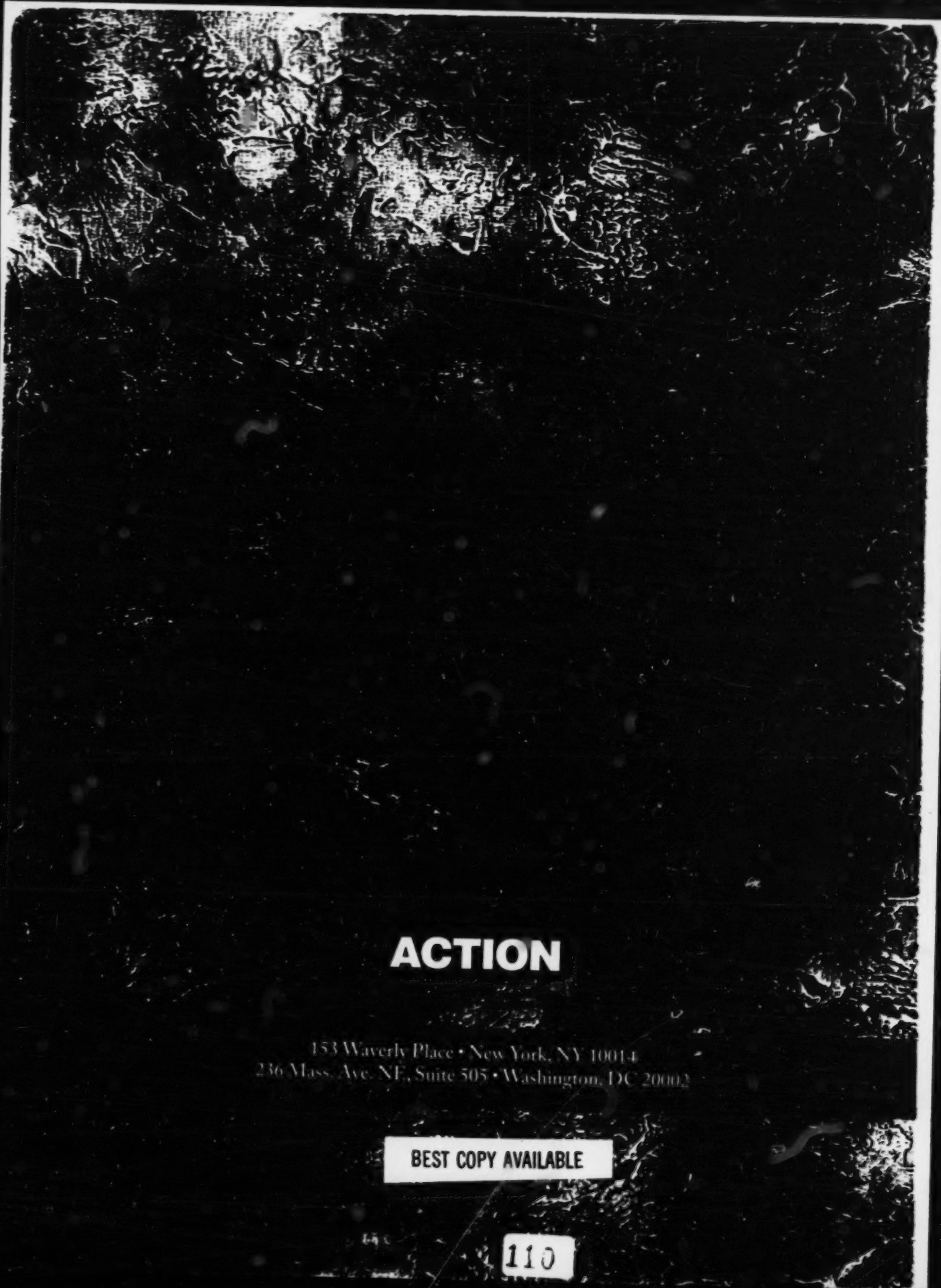
- Hallucinations (within last 30 days)
- Delusions (within last 30 days)
- Suicide attempts (within last 90 days)
- Violent, threatening, or homicidal behavior (within last 90 days)
- Taking psychotropic medication not approved by Haymarket Center's Medical Director
- Not able to participate in program activities

Direct referrals from psychiatric hospitals of patients currently residing in their facility must first receive psychiatric clearance from a member of Haymarket Center's psychiatric team.

Patients with mental health issues who have previously been given clearance by Haymarket Center's psychiatric team for admission to another Haymarket Center program will need to be reassessed by the psychiatric team for appropriateness of admission to the other program.

Medical Status: Patient must be able to care for self and participate in required activities.

Residential Requirements: Patient must be living in Illinois if seeking public funding.



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